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Adolescent and staff experiences of self-cutting behaviour in residential settings: A qualitative study

VIVIEN NORRIS

Submitted in partial fulfilment of the requirements for the degree of
DOCTORATE OF CLINICAL PSYCHOLOGY

CLINICAL PSYCHOLOGY
SALOMONS CENTRE
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DECLARATION

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Signed *Vincent Nouri* (candidate)

Date *6.7.97*

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I would like to thank my supervisor Dr John Coleman and also Lynne Benjamin and Rudi Dallos for their invaluable feedback and encouragement.

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ABSTRACT

This qualitative study explored the subjective experiences of young people and staff around self-cutting behaviour in residential settings. Ten young people and twelve staff members from three settings were interviewed. Three main areas were explored: 1) explanatory frameworks used to make sense of cutting; 2) the impact of cutting on others; 3) staff responses to cutting and how these were experienced by young people. An interpretative phenomenological approach was used to analyse the data.

A wide range of accounts was articulated and there was a high level of consistency in the data. Intrapersonal explanations for cutting predominated, but the cutting had a powerful and generally negative effect on others. The role of carer was identified as central and parallel processes occurred for young people and staff when they were in the carer role. The findings were discussed and developed into a model which attempted to bring together the intrapersonal and interpersonal cycles that appeared to be operating. Wider social issues were also considered.

It appeared that the phenomenon of self-cutting occurred in the context of overwhelming experiences which were unbearable for all concerned. There was significant difficulty in integrating the confusing and conflicting experiences associated with cutting and this led to polarised and rigid views. It was concluded that a multi-dimensional approach which includes intrapersonal, interpersonal and group processes as well as wider social issues is needed to increase understanding of this challenging area. The findings were related to the literature and research and clinical implications suggested.

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1.0 INTRODUCTION

“Self-mutilative behaviour is among those acts that seem to delimit human experience” (Walsh & Rosen, 1988, p3). Self-mutilation is complex and poorly understood behaviour which poses significant management problems for clinicians. It evokes powerful feelings in carers “as if the presence of a self-mutilator threatens the sense of physical and mental integrity of those around him or her” (Favazza, 1987, p15). Recent publications of users views have highlighted the extent to which people who self-harm feel misunderstood and badly treated by professionals (Spandler, 1996).

There is a significant gap in the literature around adolescent and staff experiences of self-harm, specifically self-cutting, which the current study aims to address. Residential settings for young people provide a particularly vivid context for examining self-harming behaviour as the professional role is often explicitly to protect young people from damaging themselves. It also allows the behaviour to be explored from multiple perspectives.

The study adopts a qualitative approach and begins by exploring definitions and the context of self-cutting behaviour. This leads to a discussion of the development of self-cutting in adolescence, a brief review of the literature regarding current explanations and models for understanding self-cutting and the issues raised in residential settings. The arguments for choosing a qualitative methodology for this study are then presented followed by the research aims and guiding propositions.

1.1 SELF-CUTTING IN CONTEXT

Self-harming behaviour is historically and culturally defined (Warren, 1997). It is not a new phenomenon, having been referred to in the Bible (Revised English Bible, 1997) and various forms of self-harm are culturally sanctioned or even encouraged. The role of social construction in the definition of self-harm is clearly evident. Walsh and Rosen (1988) believe that self-harming behaviour should be considered on a continuum from those behaviours such as smoking, which are socially acceptable, to those which would be seen as indicating disturbance, such as self-cutting. Views regarding what would be seen as disturbed or dysfunctional behaviour change over time and depend on the group whose views are sought.

Definition

The literature on self-harm uses a variety of terms to refer to this phenomenon, such as self-mutilation, self-injury, parasuicide and self-wounding. These are often used inconsistently, the definition of self-harm being likened to a 'semantic paella' (Burrow, 1992). This situation reflects the broad range of behaviours that are intentionally carried out by individuals to cause damage to their body. In particular, the distinction between various self-harm behaviours and suicide is often unclear.

Several authors have suggested that the term self-harm is used as a family name which subsumes different types of behaviour (Warren, 1997). One useful distinction is separating those behaviours that result in internal damage (e.g. self-poisoning) from those involving external damage (e.g. self-mutilation) (Tantam & Whittaker, 1992). The term self-

mutilation is often defined broadly to include behaviours ranging from minor cuts to severe self-alterations, such as amputation of limbs, but at other times is restricted to the latter. In this study the term self-mutilation will be used when citing the literature where it refers to acts of self-wounding which are repetitive and of low lethality as distinct from the severe and rare self-alterations that are associated with psychotic individuals.

Cutting has been found to be the most common method used for self-wounding (Favazza & Conterio, 1988) and a wide variety of implements are used. Other methods include hair pulling, head banging and interfering with wounds. There is a growing consensus that suicidal behaviour can be reasonably well distinguished from self-cutting, but that there may be a subgroup of people who cut, who at times become seriously suicidal (Walsh, 1987, cited in Walsh & Rosen, 1988). It cannot therefore be assumed that someone who cuts will not in the future commit suicide.

This study focuses on acts of cutting which ranged in severity from superficial scratches to lacerations requiring stitching. The term 'cutting' is used as it is widely used among young people and staff and represents an accurate description of the behaviour. Definitions of cutting were explored in the study.

Prevalence

The prevalence of self-mutilation in the general population is hard to establish as there is evidence that self-harm generally is grossly under-reported (Favazza, 1989). In the UK it is estimated that 1 in 600 adults annually wound themselves sufficiently to warrant hospital treatment (Tantam & Whittaker, 1992). Epidemiological studies show an increase in the

incidence of self-harm in recent years (Walsh & Rosen, 1988) and a greater prevalence in the 18-35 age group (Favazza, 1987). The typical self-mutilator has been found to be female, adolescent or young adult, and intelligent, but the limited research literature may be obscuring the range of people who self-mutilate (Darche, 1990; Favazza & Conterio, 1988; Suyemoto & MacDonald, 1995).

Self-mutilation is associated with a range of diagnoses, most commonly borderline personality disorder (Walsh & Rosen, 1988), but also depression, obsessive-compulsive disorder, eating disorders, alcoholism, schizophrenia and some learning disabilities (Brittlebank, Cole, Hassanyeh, Kenny, Simpson & Scott, 1990). Self-mutilating behaviour is listed in DSM IV as one of the characteristic features of borderline personality disorder (APA, 1994). Several studies have found that people who self-mutilate are likely to have histories of physical or sexual abuse as children (Carroll, Shaffer, Spensley & Abramowitz, 1980) and come from families characterised by disruption and deprivation (Rosen, Walsh & Rode, 1990).

Self-mutilation has been reported in a wide variety of settings and has been found to be particularly prevalent in inpatient settings for adolescents, reaching an incidence of 40 per cent (Darche, 1990). Many adolescents also start self-cutting while in residential settings (Ghazziuddin, Tsai, Naylor & Ghaziuddin, 1992).

1.2 PSYCHOLOGICAL MODELS OF SELF-HARM

Three broad psychological models have provided accounts of self-harming behaviour. These are cognitive behavioural, psychodynamic and systemic and all see self-harm as occurring within the context of wider personality and relationship difficulties.

Cognitive behavioural accounts propose that self-harm comes about due to a combination of predisposing and precipitating factors that develop into a self-maintaining cycle (Lacey, 1997). Predisposing factors include past and current psychiatric illness, depression and poor self-esteem due to experiences of abuse. Events such as arguments, experiences of loss or hurt precipitate intense negative emotions and hopeless thoughts which may lead to an act of self-harm. Poor problem solving skills, particularly in relation to managing relationship difficulties are thought to play an important role (Hawton, 1996). Whether or not self-harm occurs depends on the relative influence of aggravating factors, such as alcohol and isolation, as opposed to relieving or delaying factors, such as support and distraction.

The act of self-harm is carried out and is associated with benefits, such as tension reduction, venting of anger, temporary escape and prevention of worse self-harm, and disadvantages, such as injury, increase in self-disgust or guilt and loss of friends. The model proposes that both the positive and negative consequences of the act reinforce the cycle by, on the one hand reinforcing a behaviour that seems to 'work', and on the other reinforcing the individual's poor self-image by reducing self-esteem (Lacey, 1997). This self-maintaining cycle has led to self-harming behaviours being seen as addictive in a similar way to eating disorders, impulse disorders, substance abuse and violence (Favazza, 1987).

Linehan, Armstrong, Suarez, Allman and Heard (1991) have developed a treatment approach drawing on this model which focuses on interpersonal problem solving skills and regulating intense and painful emotions. Several authors also highlight how negative attitudes towards the body and beliefs that overt action is necessary to communicate with others may facilitate the development of self-harm (Walsh & Rosen, 1988; Tantam & Whittaker, 1992).

In psychodynamic accounts, self-harm involves the enactment of unconscious conflict so that conscious remembering and experiencing of the conflict does not occur but is instead replaced by action (Norton & Dolan, 1995). The conflict is thereby temporarily resolved by the destructive use of the body. This process is commonly referred to as 'acting out' and occurs in response to internal or external situations which threaten to re-awaken past experiences of emotional conflict. Self-harm is seen to develop from early relationships where the primary caregiver fails to respond appropriately to the infant's physical and emotional needs. For the child, this leads to a deep sense or fear of abandonment together with an intense but ambivalent craving for closeness. Disappointments and minor rejection are experienced as catastrophic blows to the individual's self-esteem. The experience of loss leads to primitive rage which develops into profound disintegration anxiety (Adshead, 1997). The act of self-harm brings relief by confirming the reality of the damaged self and acts also as a communication to others, of profound distress and anger (Hartman, 1996). Psychodynamic accounts have also focused on the symbolic meaning of self-harm and interpretations have gone in many different directions (Walsh & Rosen, 1988).

Systemic perspectives see self-harming behaviour as serving a function within family or community systems. The individuals that harm themselves may not perceive the interpersonal effects of their behaviour but by directing attention towards themselves may be protecting the family from something less tolerable or expressing conflicts and feelings that others may be defending against more successfully (Podovoll, 1969). In this context the family or community may be subtly supporting the behaviour in order to maintain the stability of the system. Bentovim (1992) sees traumatic experiences as organising family relationships. In situations of abuse, for instance, there is often a collusive denial or minimisation of the abuse and the family protect the perpetrator and blame the victim. For the victim, the experience of repeated traumatic stress, such as sustained abuse, leads to a deep sense of outrage and search for meaning (Terr, 1991). Within the context of the family dynamic, stressful uncontrollable events may be attributed to the self which leads to a sense of guilt and poor sense of self-worth. Expressions of outrage become directed towards the self through acts of self-harm.

Treatment

A variety of treatment approaches are reported in the literature which generally see self-mutilation as one aspect or symptom of a broader psychological problem. These have been summarised by Tantam and Whittaker (1992) and include biological, psychoanalytic, cognitive behavioural and psychosocial approaches to treatment. There is a lack of research evaluating the outcome of treatments (Feldman, 1988). It is, however, widely accepted that self-mutilation is very difficult to treat once a persistent pattern has developed (Rosen, Walsh & Rode, 1990).

1.3 EXPLANATIONS AND MODELS FOR UNDERSTANDING CUTTING

People who self-cut give complex and varied reasons for their behaviour and most are intrapersonal (Spandler, 1996). In contrast, clinicians working with people who cut have been found to be more likely to hold interpersonal explanations which are generally negative, such as seeing cutting as a punishment of others (Hartman, 1996). The interpersonal explanations for cutting have received limited attention. Many of the proposed explanations for self-cutting differ significantly and there has been little research exploring them. A few writers have attempted to categorise explanations arising from the literature but it is noted that the explanations usually come from clinical staff working with those who self-cut rather than the people themselves.

The explanations for cutting arise predominantly from two broad models, psychodynamic and behavioural. The psychodynamic explanations have tended to focus on unconscious processes occurring within the individual (intrapsychic) although a few writers address group processes. Behavioural explanations have been used to explain the 'contagion' of cutting, drawing on processes of imitation, social modelling and conformity. The various accounts for cutting will be expanded upon in the following discussion.

Writers from different theoretical orientations agree that a loss or perceived loss is a key antecedent to self-mutilation. Leibenluft, Gardner and Cowdrey (1987) summarised the sequence as follows: (1) precipitating event, (2) escalation of dysphoria, (3) attempts to forestall the self-mutilation, (4) self-mutilating act, and (5) aftermath, relief and shame. A

number of authors have postulated that this cycle may become addictive (Tantam & Whittaker, 1992).

Allen (1995) categorised explanations for cutting into three main groups: Cutting as a way to manage moods or feelings, as a response to beliefs such as intrinsic 'badness' deserving of punishment, and to manage interactions with others. Suyemoto and Macdonald (1995) arrived at eight current 'explanatory models' for self-cutting some of which have a different emphasis. Apart from the first two of these, the focus is on intrapsychic processes.

Behavioural model - Cutting begins as a result of reinforcement of destructive behaviour and linking injury with care. The behaviour is maintained by reinforcement such as attention, social status, and relief from emotional tension.

Systemic model - Cutting is a way to express the systemic dysfunction of the family or environment. The cutter protects the system by expressing the inexpressible and taking responsibility for it.

Suicidal model - Cutting is a suicide replacement

Sexual model - Cutting stems from conflicts over sexuality and menarche

Expression model - Cutting stems from the need to express or externalise overwhelming anger, anxiety, or pain that is seen as unable to be expressed more directly.

Control model - Cutting is an attempt to control affect or need. Cutting helps actively to control the affect by making it concrete, or provides punishment for affect that is perceived as out of control.

Depersonalisation model - Cutting is a way to end or cope with the effects of depersonalisation, which results from the intensity of feelings.

Boundaries model - Cutting is an attempt to create a distinction between self and others. It is a way to create boundaries or identity, and to protect against feelings of being lost or fear of loss of identity.

It can be seen that psychodynamic explanations for self-mutilation have gone in many different directions. Interpretations of the meaning of self-mutilating behaviour have included symbolic menstruation, masturbation and mother infant unity and it has been viewed as a focal suicide and a transitional object (summarised by Walsh & Rosen, 1988).

Further explanations rarely mentioned in psychological texts include the physiological aspects of cutting and wider social issues (Winchel & Stanley, 1991). Given the high incidence of self-harm in institutions such as prisons, the lack of attention to social issues is somewhat surprising (Inch, Rowlands & Solima, 1995).

The many individual case studies presented from a psychoanalytic perspective highlight the idiosyncratic nature of explanations and meanings attributed to cutting. This is consistent with the current study which attempts to explore the breadth of experiences rather than reducing them.

1.4 DEVELOPMENT OF CUTTING IN ADOLESCENCE

The adolescent population has received very little research attention in this area despite the findings that self-mutilating behaviour typically begins in adolescence (Pattison & Kahan, 1983). Many authors have identified the key developmental tasks of adolescence as

focusing on achieving ownership of one's body and separating from parents in order to establish an individual identity. Self-cutting has been related to a range of adolescent developmental issues such as separation and individuation (Woods, 1988), learning to modulate intense emotions (Doctors, 1981), dealing with emerging sexuality (Friedman, Glasser, Laufer & Wohl, 1972) and creating a stable identity (Podovoll, 1969).

A major developmental challenge for adolescents is coping with the physical changes of puberty. "Changes in the body-image of the adolescent, for whatever reason, can be expected to lead to anxiety. A change in the body is experienced as an alteration of part of the self" (Malquist, 1978, p815). Adolescents who self-mutilate have been found to show pervasive patterns of disrespect, discomfort and debasement of their physical selves which suggests that self-mutilation is only one way in which these adolescents express bodily alienation (Walsh, 1987).

1.5 CONTAGION

Interpersonal and group issues around cutting come to the fore when there are 'epidemics' or apparently 'contagious' episodes of cutting. The phenomenon of contagion of cutting has been noted by many researchers and is generally defined as a sequence in which one individual inflicts self-injury and then others in the immediate environment also do it (Walsh & Rosen, 1985). This appears to be unlike other behaviours such as aggression, fire setting and running away. Most references to contagion describe episodes of wrist and forearm cutting that occur in residential settings (Gardner & Gardner, 1975; Kroll, 1978) which is

consistent with the view that social or group factors are especially influential in producing self-mutilating behaviour (Matthews, 1968).

The issue of contagion has been insufficiently discussed. Most explanations for self-mutilative behaviour focus on intrapsychic processes and those that do try to take account of group processes tend to be simplistic, relying on behavioural explanations such as imitation or attention seeking. A few authors have suggested the importance of staff anxiety and peer group competition (Matthews, 1968), the restriction of movement of patients (Crabtree & Grossman, 1974) and peer customs whereby self-mutilative behaviour is associated with high status and affection and increases in direct response to staff attempts to eliminate it (Ross & McKay, 1979).

Walsh and Rosen (1988) attempted to draw together previous research and argued that a comprehensive explanation must include the various dimensions of individual psychopathology, peer group interactions and the milieu such as the institution. They propose that four main factors contribute to the phenomenon of contagion. These are (1) primitive communication patterns, (2) attempts to change the behaviour of others, (3) peer group influences and (4) responses to staff and treatment. This more complex view is helpful.

1.6 RESIDENTIAL CARE

While residential child care has come under increasing criticism, it is generally agreed that there are some children and adolescents who are unable to manage family type settings and

that residential care will continue to form part of a continuum of services for children in care (Bennathan, 1992). The young people entering residential care are usually very troubled, most having experienced severely damaging childhood events and multiple unsatisfactory placements (Cliffe & Berridge, 1991). The reasons for admission to adolescent residential care are generally complex but often include self-harm as a precipitating factor (Wrate, Rothery, McCabe, Aspin & Bryce, 1994).

Residential care may take a variety of forms from inpatient to community based settings which may differ significantly in their approaches. Incidents of attacks against the self, such as cutting and overdosing, and attacks against others, such as violent outbursts, are relatively common in residential settings for troubled adolescents and these environments are often described as volatile and intense (Rose, 1990).

Care Staff

Residential staff are in close and sustained contact with the young people in their care. From a psychodynamic perspective, Hartman (1996) discusses how people enter the caring professions for diverse reasons but often have intense dependency needs of their own which are defended against through their role as a carer. There is often a powerful need to be a perfect carer and to receive love and gratitude in return (Maltzberger & Buie, 1973).

According to attachment theory (Bowlby, 1973, 1980) and the object relations school (Ogden, 1990), the way in which people represent their early social experience may be closely linked to later patterns of relating. There is growing research evidence to support this (Patrick, Hobson, Castle, Howard & Maughan, 1994). In situations where staff

respond to manage adolescents' behaviour, it is postulated that the interpersonal expectations, feelings and defences of both the adolescent and staff member will impact on their experience and behaviour.

Much is written in the clinical literature about how young people's behaviour can obscure what they really need and how care workers can become drawn into unhelpful responses (Gannon, 1993). The overuse of staff confrontation has been demonstrated (Stock, 1991) and a lack of staff response to persistent limit testing has been found to result in high rates of restraint (Erikson & Realminto, 1983). Zeiger (1990) describes the intense emotional reactions that are evoked in staff working with difficult adolescents and how, when unaddressed, staff may become 'non-therapeutic'. He suggests that one of the most difficult daily management problems is dealing with the adolescents' intense and ambivalent dependency needs. The ongoing internal battle over how much to rely on others becomes highlighted in crisis situations, such as acts of self-harm.

Collie (1996) describes how group living situations can act as a kind of theatre where various unconscious processes are played out between the members. It is outside the scope of this paper to address these issues in detail (see Ogden, 1982) but the process of projective identification is particularly relevant and is taken up in the discussion section. Kernberg (1987) discusses how unconscious communication processes are often denied and unaddressed by staff groups and that "the patient's behaviour within the therapeutic milieu tends to induce interpersonal disturbances within the staff that unconsciously reproduce the patients' social surroundings, his intrapsychic world of object relations" (cited in Collie, 1996, p188).

1.7 SUMMARY

In summary, there is a significant gap in the literature about adolescent experiences and explanations for their self-harming behaviour. There are apparently no published studies exploring adolescent experiences of staff responses to incidents. It appears that self-cutting is a highly complex process but no current model brings together the different levels of understanding. There has been little sharing of ideas with the client group who are being represented and the current study explores cutting from both adolescent and staff perspectives.

2.0 CHOOSING AN APPROPRIATE METHODOLOGY

Choosing the most appropriate methodology for a study involves both practical and philosophical considerations (Bryman, 1988):

Practical considerations

In the current study the aim is to develop understanding about cutting from the subjective experiences of participants. There were few fixed hypotheses and the research was exploratory. There was little literature about how young people and staff make sense of their experiences and a number of authors highlighted the need for qualitative studies to be undertaken (Suyemoto & MacDonald, 1995). A meeting was held with two young people who regularly cut themselves in order to discuss how the material might most effectively be

explored. Both believed that in-depth face-to-face interviews with the researcher would generate the most genuine views.

Philosophical considerations

Barker, Pistrang and Elliott, (1994) point out that psychologists have traditionally adopted a position regarding knowledge and truth which assumes that there is a real world 'out there' which has regularities and is open to understanding through the testing of specific hypotheses. Quantitative approaches are embedded in this assumption.

The qualitative approach to research is based on phenomenology, that is the study of "that which appears real to the senses, regardless of whether their underlying existence is proved real or their nature understood" (Morris, 1981, cited in Barker et al, 1994, p74). Qualitative approaches emphasise that it is of central importance to study the meanings that people ascribe to their experiences since it is these which shape their emotional responses and actions. This does not imply a rejection of real events but accepts that each person uniquely ascribes, at least to some extent, personal meanings to them.

A number of research variations have arisen from this philosophical movement which differ in their emphasis on the content and structure of experience (Barker et al, 1994). The ongoing debate about quantitative versus qualitative research often obscures the different views within qualitative approaches which can be seen as falling on a continuum from objectivist to constructivist (Miller & Glassner, 1997). At one pole, positivists have the goal of obtaining data which come as close as possible to a 'mirror reflection' of the reality

that exists in the social world. At the other pole, radical social constructionists posit that knowledge about reality ‘out there’ does not exist and that versions of the world are constructed in the interactive process of carrying out research. This situation has been referred to as the “dilemma of qualitative method” (Hammersley, 1989, cited in Richardson, 1996, p80).

Pidgeon (1996) states “this dilemma arises from a simultaneous commitment, on the one hand to realism and science (by claiming to reflect objectively the participants’ accounts and perspectives) and, on the other hand, to constructionism through a recognition of the multiple perspectives and subjectivities inherent in both a symbolic interactionist world view and in the engagement of the researcher in interpretative work of generating new understandings and theory” (p81).

Several researchers have attempted to identify a middle or alternative position. The current study adheres to Smith’s (1995a) view where “it is assumed that what a respondent says in the interview has some ongoing significance for him or her and that there is some, though not a transparent, relationship between what the person says and beliefs or psychological constructs that he or she can be said to hold” (p10). Smith argues that there is no one correct method for analysing qualitative data and advocates that the researcher finds a method which is appropriate to the material studied and the researcher’s personal and theoretical propensity.

The current study is **phenomenological** in that it is concerned with accounts of reality rather than objective reality itself, but high levels of consistency in the data are taken to

suggest processes of ongoing significance. It is also influenced by the assumption that meanings are negotiated within a social context, known as a symbolic interactionist position (Denzin, 1995). It is, therefore, assumed that the researcher's position and views influence the process of the research. The analysis combines an attempt to unravel the meanings contained in the accounts through a process of interpretative engagement with the data, described by Smith (1995a) as an **interpretative phenomenological analysis**. Recent developments in grounded theory subscribe to interpretative views of the research process through the "researcher's disciplinary and theoretical proclivities, relationships with respondents, and the interactional construction and rendering of the data" (Charmaz, 1995, p30).

Taking this position is more consonant with the practice of analysing data. What may appear to be the 'emergence' or 'discovery' of concepts is in reality "the result of a constant interplay between data and the researcher's developing conceptualisations, a 'flip-flop' between ideas and research experience" (Pidgeon, 1996, p82). This is similar to progressive hypothesising in systemic theory. In the current study the researchers initial ideas and expectations are presented before the analysis and then a recursive process of revision and re-revision occurs throughout.

The major part of the current study is concerned with rigorous analysis of the interview data. Layder (1993, p82) holds the view that the data should "*guide* but certainly not *limit* theorizing" and that the data can and often should be interpreted in terms of wider social concepts and power relationships. The final stage of the analysis subscribes to this position.

2.1 EVALUATING QUALITATIVE RESEARCH

While the traditional criteria of reliability and validity are difficult to apply directly to qualitative research it can be argued that approaches which acknowledge the complexities of personal experiences have more ecological validity than traditional approaches. A number of authors have suggested possible criteria for evaluating qualitative studies and those applied in the current study are outlined below. It is noted that some of the criteria can be debated in terms of the qualitative dilemma discussed earlier. This study will, therefore, use the criteria as ‘guidance for good scholarship’. Harding (1991) made the distinction between ‘weak’ and ‘strong’ objectivity. In the former the multiple layers of subjectivity are obscured (as in traditional research) and in the latter the researcher makes public the full interpretative process.

The five areas for evaluating studies suggested by Barker, Pistrang and Elliott (1994) were used.

1. Openness

The researcher clearly describes their theoretical orientation and biases. This has been termed ‘reflexivity’, that the researcher should be reflective, continually thinking about the process of the research, considering the likelihood of errors of various kinds, in particular the researcher’s role in the research (Henwood & Pidgeon, 1995).

2. Replicability

Data collection methods and the process of analysis are described in enough detail to allow others to replicate the study. Lincoln and Guba (1985) advocate leaving an 'audit trail' to allow others to check the process of theory generation and interpretation.

3. Grounding

Sufficient examples of the raw data are presented to allow the reader to evaluate the categories obtained and linkage of concepts.

4. Verification

Methods are used for checking the validity of the results, for example by using analytic auditing - multiple researchers check the results against the data, and testimonial validity - results are checked with the original informants.

5. Uncovering

From the reader's point of view, the results make sense of the phenomena, enable a fuller understanding and facilitate further research questions.

2.2 RESEARCH AIMS AND GUIDING PROPOSITIONS

The study and subsequent interpretation of findings was influenced by a number of factors; 1) the author's experience in residential work with adolescents prior to training which was psychodynamically oriented, 2) aspects of the current literature on self-harm, 3) preliminary discussions with young people and staff, and 4) social constructionist theories on the nature of narratives and accounts. These will be presented leading to a number of propositions which guided the research process.

1) My clinical work provided first hand experience of the powerful and usually negative feelings that are evoked when young people repeatedly cut themselves. 'Not thinking' was a frequent response to feeling confused and overwhelmed. Dynamics among young people and the staff group were also very apparent with staff responses often being influenced by a host of personal issues including their sense of themselves as carers. These processes were understood primarily in terms of unconscious dynamics, drawing on the work of various theorists such as Winnicott (e.g. 1965).

2) The polarisation and conflict which seems common when working in this area is reflected in the literature. The views of people who cut (Spandler, 1996) and professionals writing on the subject present contrasting accounts which are rarely integrated. The professional literature on cutting frequently uses pejorative terms to explain cutting, such as 'manipulation', and 'service users' feel mistreated. The dominant emphasis in the literature is on either intrapersonal accounts or on reducing the multiple levels of meaning and understanding to discrete and unsatisfactory models. Some authors have taken a more

complex approach. Hartman (1996) raises the importance of the internal world of the therapist and group dynamics within the peer and staff group. Walsh and Rosen (1988) discuss contagion of cutting in some depth and move beyond previous social modelling explanations.

3) Preliminary discussions with staff and young people highlighted the intense and overwhelming feelings that are associated with cutting. The confusion that staff feel about how to respond and the surprise expressed by young people on being asked their views was striking. It appeared that an exploration of how people make sense of their experiences around cutting behaviour was both highly relevant and potentially helpful.

4) Recent theorists have emphasised the interactive and social character of accounts and their varied functions. Harvey, Orbuch and Weber (1990) suggest that story-like explanations of events typically develop in stressful situations and have implications for the individual's social identity. The account, which may include antagonists and protagonists, may provide a framework for people's search for meaning (Thomson & Janigian, 1988). Accounts include the person's unstated assumptions and may be seen as serving as much a communicative-persuasive mission as they do a function of personal explanation, meaning-making and self-insight (Harvey et al, 1990).

It is suggested that the influences outlined above acted as 'lenses' (Hoffman, 1990) which coloured the development of the study and the author's perceptions and analysis. Efforts were made to be vigilant to possible biases and to offer alternative ways of understanding the data.

Aim

The aim of this study was to explore the subjective experiences of young people and staff around self-cutting behaviour in residential settings. It was hoped that an examination of the ways that people made sense of their experiences would add to the current theoretical understanding of self-cutting and its impact on those working with it. It was hoped that consistent patterns, themes and descriptions of processes would emerge from the accounts allowing some tentative generalisations and models of the phenomenon of cutting to be developed. The following propositions guided the research.

Guiding propositions

It was predicted that the cutting behaviour would evoke powerful and contradictory feelings in staff and young people and that differing perceptions would reflect these subjective experiences. It was not known how the accounts from young people and staff would relate to each other but it was expected that there would be areas of overlap and difference. It was expected that the process of interviewing would help participants to articulate previously unstated, unattended or subjugated understandings, explanations and beliefs. It was expected that interpersonal and group processes would emerge as important, specifically that the engagement of staff in a care response would be central. Finally, it was anticipated that the author's previous experiences and interests would colour the research process but would also be challenged by it.

The following areas were explored.

1. The explanatory frameworks offered to make sense of the cutting.
2. The subjective emotional experiences of young people and staff.
3. The responses to the behaviour and how these are experienced.

3.0 METHODOLOGY

3.1 DESIGN

A mixed design was used. A between groups design was chosen in order to enable some comparisons and contrasts to be drawn between the subjective experiences of young people and staff and to explore the relationships between them. At the same time the intention was to explore in depth participants' subjective experiences and accounts. In order to create the greatest potential for contrasting accounts, participants were sampled from a number of settings and males and females included in both groups. Different types of residential unit were sampled so that findings which emerged consistently could be seen to be independent of treatment orientation. The design was therefore sensitive to contextual influences allowing greater generalisability.

3.2 RESEARCH DIARY

A research diary was kept throughout which recorded the author's thoughts feelings and experiences as the study developed. The aim was to provide a detailed account of the research process as it developed (Extracts of diary in Appendix I).

3.3 PARTICIPANTS

Two groups of participants were interviewed: ten adolescents who regularly self-cut and twelve residential members of staff who were regularly involved in responding to incidents of self-cutting. Managers of three units were contacted and two agreed to support the research (Appendix II). Participants were recruited by distributing information about the research and asking for volunteers following the ethical considerations addressed in section 3.8 below. All participants were interviewed in the residential settings.

3.4 SETTINGS

Participants were recruited from three settings which all provided full time residential care. Contrasting settings were chosen in order to provide the maximum range of accounts. Staff and young people were recruited from a community home and a psychiatric unit. Two staff members were also recruited from a therapeutic community but it was not possible to recruit young people.

Community home

This consisted of three staffed houses situated in a town, each accommodating 3-5 young women aged 13-18 years. The homes provided specialist long-term care for young women who had experienced sexual abuse. The staff were predominantly residential social workers and external consultancy was provided by a Clinical Psychologist and a Psychiatrist. There was a constant staff presence but as much independence as possible was encouraged and extensive use made of local educational and leisure facilities. Some of

the young women were in individual therapy. Most of the young women had long histories of being in care and a complex range of difficulties including self-harm. An eclectic approach to care was taken with an emphasis on creating a safe environment.

Psychiatric unit

The adolescent unit was based within a psychiatric hospital which provided a range of other clinical services. It was an acute psychiatric unit that provided short-term care for 24 males and females aged 10-18 years. It was staffed primarily by nurses with specialist training and consultancy was provided by psychiatrists. Admission was often precipitated by a breakdown in care elsewhere and self-harm as a key factor was common. There were quite strict restrictions in terms of freedom of movement although organised trips out were frequent. A range of educational and leisure activities as well as therapeutic groups were run on the unit. A consultant led multidisciplinary approach to treatment was used, based on the medical model and drawing on aspects of therapeutic milieu practice.

Therapeutic Community

The therapeutic community provided specialist long term care for 20 males and females aged 13-20 years. It was staffed by a large group of residential workers drawn from a variety of disciplines including teaching and psychotherapy. Consultation was provided by a Consultant Psychiatrist and Psychotherapist. The Community approach was based significantly on group work and centred around understanding the meaning of behaviour. The core tenets of therapeutic community practice were adhered to (Rapoport, 1961).

3.5 ADOLESCENT PARTICIPANTS

Five participants were recruited from the community home and five from the psychiatric unit. They ranged in age from 14 to 18 and there were 8 females and 2 males. Detailed histories were not gathered as this was a sensitive area which the young people were reluctant to discuss. In the context of this study it was not thought appropriate to read their notes. What was known was that all had experienced significant family disruption, almost all had been sexually abused and some had a long history of being in care. Three young women said there was no one they would regard as family, the others gave no information or had some family contact.

They had been cutting themselves for varied lengths of time, from 2 months to 5 years. The cutting was of varied severity, from scratches without drawing blood to severe lacerations which required stitching. Several participants had made previous suicide attempts and all referred to having used other forms of self-harm such as overdosing (Further participant details in Appendix III).

3.6 STAFF PARTICIPANTS

Five participants were recruited from the community home, five from the psychiatric unit and two from the therapeutic community. The staff participants ranged in age from late 20s to early 40s. There were 9 women and 3 men. They had been working in residential settings with adolescents from 1 and a 1/2 to 10 years. They reported involvement in incidents of cutting from several times daily to monthly. All said that the frequency varied

significantly, primarily depending on the young people currently in the unit. The psychiatric unit staff reported a very high rate of cutting at the time of interviewing, usually daily, whereas the other staff were involved on not more than a weekly basis.

3.7 MEASURES

The data was obtained from face-to-face interviews using a semi-structured interview schedule (Appendix IV). Separate schedules were used for adolescents and staff which addressed the three main areas relating to the propositions, subjective experiences, explanatory frameworks and responses to cutting. Interviews were recorded verbatim by hand as far as possible.

Development of the interview schedule

The author initially consulted with two adolescents who self-cut to discuss the best approach to collect the data. It was agreed that a semi-structured interview would be most appropriate and the adolescent schedule was devised based on the author's ideas, the adolescents' suggestions and a review of the literature. A number of staff members made comments on both schedules and amendments were made according to feedback. The first two participants piloted the schedules and minor changes were made.

The interview schedules were divided into seven sections, outlined below, prefaced by standard instructions and time for completing the consent form, discussing confidentiality and asking questions. The researcher checked how the young people were feeling at various points during the interview.

Section 1 Background details

This section recorded brief background details; the participants age and how they came to be in residential care/ how they came to be working in the unit. All were asked to define what they meant by ‘cutting’.

Section 2 Experience of cutting

Adolescent participants were asked for details about their cutting behaviour, how long they had been doing it, frequency, where on the body and what it was like. Staff were asked parallel questions about their experiences with young people and also how they felt about working with people who cut.

Section 3 Explanations

This section focused on adolescent and staff explanations for cutting, whether certain situations and feelings lead to it, whether the cutting changed anything and how the adolescent felt about others knowing about incidents. Adolescents were asked for their views on why other young people cut and how they felt about them. Staff were asked about the impact of the cutting on the young person, other residents in the unit and the staff group.

Section 4 Response of others

This section explored the responses of others around incidents of cutting, how staff and peers respond, what this feels like and what the young people would want ideally.

Section 5 Specific incident

The participants were asked to think of and describe in detail a recent incident of cutting. They were asked what happened, why they thought they/ the young person cut that time, how others responded and their feelings about this.

Section 6 Other self-harm

All participants were asked how they thought other forms of self-harm related to cutting.

Section 7 Debriefing

Several debriefing questions were asked including how they felt about the interview, areas not covered and any questions they might have. Adolescent participants were asked if they wanted a follow-up appointment to check their transcript and reflect further on the interview. Almost all did and these meetings were carried out following the interviews. They were also asked if they wanted to discuss the summary of the results and some said they did. A handover was held with a member of staff immediately following the interview and the information to be shared was first discussed with the young person. Staff participants were asked if they would like to see a summary to comment on and all were sent copies of their interview responses to check for accuracy.

3.8 ETHICAL CONSIDERATIONS AND APPROVAL

There were many ethical considerations regarding the study, in particular whether the interview with the young people would uncover difficult feelings and precipitate cutting. Several discussions were held with staff and young people and following these and the pilot

interview a protocol was put in place. Two ethical committees were approached and an extended discussion held regarding consent and the bounds of confidentiality. The two committees emphasised slightly different issues but the following arrangements were agreed. (A detailed list of the issues and Ethical Approval letters are presented in Appendices V and VI).

1. An information sheet outlining the research was made available and the researcher offered to visit young people in the residential setting to talk about the project (Appendix VII). The clinical team decided which young people might be interested and appropriate (e.g. not currently suicidal) and the key worker talked with the young person.

2. Consent for participation was stressed as voluntary and a range of explicit comments made about this, 'you don't have to meet with me if you don't want to, you can stop whenever you want and can miss out questions'. Consent was also required from the unit, the responsible clinician, social services or parent/guardian where appropriate. When the young person had agreed to be interviewed the researcher checked on the day of the interview that they were still interested and obtained additional consent from the senior member of staff on duty at the time of the interview (Consent Forms in Appendix VIII). Attention was given to the emotional state of the young person on the day and whether any events such as difficult phone calls or impending visits left the young person more vulnerable.

3. The bounds of confidentiality were discussed explicitly with the young person. There was an inherent tension between the young person's right to confidentiality and the

unit's responsibility for their well-being. It was decided that information given in the interview that had a direct impact on the young person's likelihood of harming themselves, such as disclosing that they were storing blades, would be handed over to staff at the end of the interview.

4. The debriefing section of the interview was intended to facilitate the expression of feelings about the interview, establish the emotional state of the young person and discuss what information, if any, needed to be handed over to staff. A short handover meeting was held following the interview with a member of staff and the young person was present. Even where there was no information to be handed over, this served to remind the member of staff that the young person had been discussing painful issues.

5. Follow-up visits were arranged for the young person to go through their transcript and to discuss the summary. The aim was to promote maximum involvement of the young people at each stage of the research.

The interviews with staff members followed a straightforward procedure whereby they were informed of the research and volunteers recruited.

3.9 PROCEDURE FOR ANALYSING INTERVIEWS

All transcripts were typed for each participant. Participants then checked and made any changes to them. The analysis was broadly structured by the main areas addressed in the interview, subjective experiences, explanations and responses. Within this, the types of

accounts given were explored, for example by drawing out intrapersonal versus interpersonal explanations.

The method of analysis was interpretative and phenomenological. It was assumed that the analysis would be influenced by the interaction between the researcher and participant and by the researcher's views and experiences. Detailed notes were written about the researchers experience of the analysis and other people, including participants, were engaged in discussion at all stages. Aspects of grounded theory were drawn upon, in particular, the method of constant comparison. This involves sifting and comparing different elements of the analysis, verbatim data, emergent categories and theoretical propositions and sensitises the researcher to the full range and complexity of the data (Pidgeon, 1996). The following recursive process was used to analyse the transcripts.

1. A number of transcripts were initially read in detail and anything that seemed interesting or significant was noted in the left margin. These comments were primarily reflections. The transcripts were then re-read and the right hand margin used to note down emerging themes using words which captured the quality in the text. These included more abstract themes such as 'ambivalence'. Links and connections were made between sections of texts as they became apparent. This process was repeated with the remaining transcripts.

2. A large sheet of paper was then used to set out the key words/themes and to begin to make connections between them. The issue of being a carer for example emerged as a central theme with a host of different experiences subsumed under this category, such as

the desire to rescue or feelings of impotence. At this stage the categories remained close to the data but a complex web of interconnections was developing and there was a pull towards increasing abstraction.

3. The original transcripts were then returned to and a rigorous process of sorting and categorising was carried out. This was done by hand as it provided the clearest overall picture of the data as well as allowing detailed sifting of extracts. The verbatim data from all transcripts was separated into sentences or short paragraphs and these were numbered so that each section could be traced to the original later. The sections of data were cut out and sorted into piles of broad themes. Each theme was then sorted into more detailed categories. At the end of this process the main themes and subcategories were arranged on computer with the groups of examples from the verbatim data. Some data which it had not been possible to categorise were included at the end.

4. The data in this form were sent to three researchers who examined and made comments on it and their feedback was incorporated. Discussions were held with a number of parties to think about moving towards a conceptual framework which would capture the material in a more summary form. A summary was then written and disseminated to participants and other interested parties for comments. All comments received were integrated into the analysis.

5. The final stage of the analysis involved a shift from the descriptive to theoretical and integrative organising principles were suggested and presented in diagrammatic form. Again, feedback through discussion informed this process.

4.0 FINDINGS

A summary of the categories that emerged is given in Table 1 below. This is followed by presentation of the themes and subcategories in detail with examples of verbatim extracts.

Table 1: Summary of categories

EXPLANATIONS

- a) **Intrapersonal**
 - (I) Survival strategy versus suicide?
 - (ii) General coping strategy
 - (iii) Calm/ release/ distraction
 - (iv) Self-hate/ punishment/ internalised anger
 - (v) Making ‘Concrete’ - bad things from inside to outside

- b) **Interpersonal**
 - (I) Communicating level of distress
 - (ii) Punishing others
 - (iii) Attention/ status

c) **Types of Cutters?**

EMOTIONAL IMPACT OF CUTTING ON OTHERS

- (I) Fear and anxiety
- (ii) Sympathy and concern
- (iii) Confusion and impotence
- (iv) Anger
- (v) Cut off

PRACTICAL RESPONSES OF OTHERS

- a) **Staff responses to cutting**
 - (I) Practical care/ repair
 - (ii) Engagement/ rescue
 - (iii) Staff conflict of opinion

- b) **Young people’s experience of responses**
 - (I) Ambivalence about being cared for
 - (ii) Staff don’t care
 - (iii) Do nothing
 - (iv) Accept/ normalise cutting?
 - (v) Prevent serious damage

The analysis is organised as follows. First the context of cutting is described, how and where it happens and how it is defined. This is followed by an examination of the three main areas of analysis; (1) the explanations offered by staff and young people for the behaviour, both those that attribute it to processes within the young person and those that consider interpersonal issues; (2) the emotional impact cutting has on others and (3) the responses to cutting and how these are experienced by the young people.

The accounts given in each of these main areas have been organised into themes and illustrations of verbatim data are given. A parallel process occurred for almost all categories so within each category both staff and young person examples are included. The categories that emerged were not mutually exclusive in that participants accounts fell into more than one category. For (3) responses to cutting, staff and young person extracts are presented separately. Extracts are in italics and prefaced by ‘yp’ (young person), or ‘st’ (staff). Further examples of extracts are included in Appendix IX.

4.2 CONTEXT - WHAT, HOW, WHERE AND WHEN

With few exceptions, young people and staff agreed on definitions of cutting. ‘Cutting’ was distinguished from ‘scratching’. Scratching was seen as making superficial marks whereas cutting involved blood flowing. Scarring was consistently mentioned as important. Deeper cuts were seen as more significant, suggesting a hierarchy of seriousness. The idea that some cuts are more significant than others permeated through the study and into views

regarding whether other young people were seen as 'real' cutters. All the young people interviewed saw themselves as people who 'cut' regardless of severity.

A wide range of implements were used and particular implements were popular in the different settings. The areas of the body cut ranged from the outside and inside of the lower arm, which was said to be most common, moving to the legs and less frequently to the stomach, face and in one case the genitals. Several people moved from arms to legs when they had 'run out of room'. Many descriptions of the act of cutting referred to the use of ritual such as using music and adopting particular rules, such as only being able to use a particular blade if no one knew about it then having to discard it.

Cutting happened almost exclusively in private, in bedrooms and bathrooms and at times alone outside. The issue as to whether cutting remained in the private arena raised differing young person and staff views. Young people saw themselves as involved in a private activity where contact with staff primarily arose from the need for practical care, bandaging and stitching. Staff in contrast saw cutting as involving many public aspects such as the frequent display of wounds following cutting and ways in which the young people let staff know that they had cut. The private/public issue raised conflicting opinions and young people also showed significant ambivalence in their behaviour by for example hiding in their room and barricading themselves in while also playing very loud music.

Young people and staff saw the frequency of cutting as varying across time and within individuals. Young people said they cut from 15 times a day to once a month and reported being influenced primarily by mood and having the means and opportunity to cut. Staff

reported being involved in incidents from several times a day to once a month. The young people thought that a lot of cutting went undetected.

4.3 EXPLANATIONS

A wide range of explanations were given. These divided into (a) intrapersonal and (b) interpersonal explanations. Young person and staff explanations predominantly involved processes that were going on within the young person. Young people almost without exception saw their cutting as an internal process. They did, however, see some other young people as cutting for interpersonal reasons and many comments were made about different 'types of cutters' (c). All explanations referred to cutting having only a short-term effect with the desire to cut again returning quickly.

a) Intrapersonal explanations

(I) Survival strategy/ suicide?

Cutting was overwhelmingly experienced as a short term way of coping with unbearable feelings of anxiety, depression and anger and not as a means to die. A few young people however expressed suicidal feelings at times of cutting and on occasions some young people and staff were very concerned about the level of harm that might be inflicted particularly when young people were in a dissociated state and did not appear to be in control of the degree of harm.

yp - I do want to die but I want to be cared for more.

yp - *You do it to keep going. When you start it's not like you worry about how deep you cut .. then your arm goes numb and you go deeper and deeper you're going so you don't realise how deep you've gone.*

st - *It was scary .. trying to patch people up ... seeing blood and blood everywhere. You never know at the end of the day, can only assume how far they'll go, especially if they're going through a stage of doing a lot. If something goes wrong, how far will they go? Fear that they'll go too far and not mean to. One day it will just go so wrong.*

(ii) General coping strategy

Cutting was seen as one general coping strategy from a limited repertoire of responses which involved doing something.

yp - *Because I don't know how else to deal with my problems. I either cut, take aerosols or run. It's a way of coping when I get really stressed out.*

yp - *I cut myself because she left but I had a lot of problems as well. I thought I could get everything out then by cutting. I knew that that was a time that I could get all my anger out rather than take it out on other people. If I cut then I wouldn't have to cut the next day because of something else. I cut for lots of things.*

st - *Lots of everyday situations lead to the cutting. Some people are better first thing in the morning, the time of day determines how they feel. Often early evening is the worst*

time. Events like meetings that are going on, or anything that involves being in a group situation, having to communicate, sessions that throw up emotions. There are lots of groups daily that bring up all kinds of emotions. They are very vulnerable at that time. Phonecalls, visits, it could be anything, really anything. The list could go on for ever.

(iii) Calm/release/distraction

The predominant explanation of cutting was that it provided relief and distraction from overwhelming feelings and had a short term calming effect. This was often followed by feelings of shame and self-disgust, particularly about the wound. Sometimes a build up of tension was described and a variety of triggers such as contact with relatives or unpleasant memories were identified. Others talked about it 'just happening' without really knowing why.

yp - I bottle up problems, go too far, get too stressed and start hacking away. It calms me down, I do it to myself to feel more calm.

yp - After I've cut I feel almost drunk. Makes me feel a lot better, kind of like a euphoria, lasts about 10 minutes. Then I get depressed again, worse than it was before. It upsets me a bit that I've got scars. The deeper it is, the more it bleeds, the more stitches it feels better. Each time to get the same effect you've got to do it more. It feels good to look at a fresh cut when it's bleeding.

st - I think there's an initial release, they actually feel relief of stress come out of themselves but later, especially when they're stitched up, they're quite disgusted with the

way their legs, chest etc look. Some people are quite pleased when the scars are healing but then cut again.

st - The experience I've had, the girls say they feel very contented for the short time after it's happened. Released something, like opening a can of worms and some come out. But it doesn't last long.

(iv) Self-hate/ punishment/ internalised anger

This strand of explanations was particularly strong among the young people who cut themselves seriously. The cutting arose from a profound sense of worthlessness and self-hatred. Cutting was seen as a justified punishment against the self or as a means of redirecting anger that could not be expressed towards others.

yp - Well I used to cut my stomach because I used to think if I looked really ugly no man would ever rape me and that .. because I hate myself and that's the only way of punishing myself and because I don't want to die there's nothing else I can do.

yp - It doesn't hurt, it's just like you don't have a care in the world, or like no one cares about you. I do it to hurt myself, sometimes so I can feel physical pain rather than just what's inside, because I feel guilty of some of the things that are happening in my life. It just feels like pay back time now. Punish myself. It never seems to hurt but when I've finished it hurts. I want it to hurt. It's not so much a relief. I never felt better afterwards, I had to do more, it never felt enough. Sometimes I used to just sit for 25 minutes and go over and over again until I had no skin on my arms. It's like there's nothing inside, I

didn't feel anything. For me it feels like there's nothing there. I don't really care what I look like from day to day.

st - When the girls cut they're feeling really low, unsafe, out of control, powerless, no self worth, basically like it's all too much for them, they haven't got anything. They hurt so much that they hurt themselves, to see if they still exist, because they deserve it. Often they're very very low when cutting, feel shit, worthless, no good.

Staff participants described a number of situations where young people appeared to be re-enacting abuse which are consistent with this theme.

st - I came in and everyone was milling around. You just wanted them to go back to bed but you know what it was like, lots of excitement and one of the residents 'looking after' her. I told her we had to go to the hospital. She was incoherent but refused to go with anyone except for (male member of staff). I said no. I think it's interesting who these kids tell about having cut, I mean the sexual element was very clear and there was no way I was going to agree. But then, it was late at night and sometimes it's easiest to take the path of least resistance. But I said she would have to go with ...(female member of staff) and eventually we coaxed her. With this young woman there seemed to often be a kind of re-enactment of something, so that she would cut badly but refuse help except from her special male member of staff.

(v) Making 'Concrete' - Getting bad things from the inside to the outside

This theme was described by all young people. Internal pain and distress is felt to be unbearable and out of control, and cutting provides a focus and converts the confusion into a concrete and sure form, providing some form of meaning. Being able to exert some control over the pain was felt to be important as was providing concrete proof of how awful they really feel.

yp - It's funny, it's sort of, it hurts and you think, my God that hurts, but it's hurting somewhere else, but it doesn't hurt your soul, your heart. It's quite localised, the pain, it's quite easily bearable. I always do it until the pain makes me feel sick then I forget what I was initially pissed off about. Simple displacement. It feels like a relief, swap one pain for another and normally that other pain won't come back if you keep doing it. It'll die its death and won't come back again until there's another reason for it to come back.

yp - I feel different afterwards, feels like you've done something, don't feel so helpless anymore, you've done something. If I'm really down about something cutting makes me feel happier, come out of it. If I feel low, I cut and my mood lifts. Cutting my arm is the type of pain I can control, can stop and start. I can't do that with the pain in my head.

yp - I suppose I've talked about self-hate. Not feeling a part of things and then I cut and I do distance myself from other people, representing the gap I feel. I feel this gap between me and my friends so when I cut I create a gap again. It's nice to tie things down. Things are less questionable, things become more secure, you can feel the gap and show the gap. All the time it's just a thought in the head it can be questioned or changed.

st - For some of them it's a lack of self-worth. They're 'damaged goods' anyway, maybe they've been abused. They take the pain away from the heart and that's much more understandable. Sometimes people feel that getting the blood out cleans out the badness and it also lets them be looked after. It's saying, this is not normal, I need help, I'm not coping.

st - Normally these kids you know they're strange on the inside but they look OK on the outside and when someone's done that they don't. Summer comes and it's hot weather and then you're really faced with a choice, a lot of people are then covered up. I think that thing of covering up, having something to cover up on the outside as well as on the inside, marks of shame, violation and abuse, and it is a self-abuse, I think that's a very interesting term for these kids. There's a symmetry, perhaps a sense of satisfaction, a sense of rightness then that there's something wrong with them on the outside.

b) Interpersonal explanations

A small number of explanations related to the communicative function of cutting. Central to this was whether staff were made aware of the cutting. All staff said they thought they knew about the majority of incidents because the young people communicated it to them in one way or another. A few young people agreed with this but many were ambivalent.

(I) Communicating level of distress - this is how much I'm hurting

A few young people alluded to the importance of showing staff how they felt inside and this was seen by some staff as important and as an effective way of engaging in a caring interaction.

yp - Sometimes it's my way of talking to people, a way of saying things aren't going well at the moment or I feel bad. Sometimes when I cut I can't talk, for example if I come back from leave, I can't get it out so I cut. Even when I've done it I still can't talk about what's happened, can't get any words out after. Sometimes I can talk about things.

st - You've still got a chance to interact...it's not withdrawal. They're attempting to engage you in something... as if there's still a chance of a productive road (unlike suicide).

st - Sometimes it engages staff in caring behaviour and is an opportunity to speak with the person. In a sense it 's quite an efficient method for staff to give her care.

(ii) Punishment of others

Staff made references to cutting as a way of punishing others, 'see what you made me do' but young people made no references to this.

st - Things that spark it off could be an argument, setting boundaries and their way of pushing it is to cut. eg if they're angry at the primary nurse they will cut to get at them or their parent. Most of them would deny this.

st - They might be angry at the person that abused them 'look what so and so's made me do, they've put me through all this'.

st - It's taking the form of a quite deadly game. Don't think it's about dying..but I think that it's a possibility if you just deal with the behaviour...shoving it into a corner. Escalating seems to be in response to people trying to stop it. Like an awful game of catch me..we can't.

(iii) Attention/ status

Several explanations revolved around the theme of playing games to secure staff attention.

A related theme was the way in which cutting was used to gain status and acceptance within the adolescent group. These explanations came from some staff and from young people when they spoke about other young people, not about themselves.

yp - Sometimes it felt like some of them just did it like it was a trend for everybody. Some people did it for attention, but it's no way to get attention. I don't think it's funny. It makes me angry. I suppose that's why staff see it as a game, because everyone seems to do it, not just one. The majority of the girls in the younger group really get to me because they go round boasting about it and then show their sleeves to anyone and everyone, they see it as funny. I take it seriously. It's like every time I keep trying to prove a point to the staff.

yp - Some do it as a game. There was one time when 4 people cut each other, 11, 12, 14 and 15, they all cut each other. Everyone has been cut at some time. Some 10 and 11 year olds just do it, they just sort of cut. Lots of people start cutting when they get here. For some, they see other people coping like that and they do it too, and others it's just a game.

st - There's a role model for others cutting. We always find a kid who's 'top dog' in the unit and they act as the leader of the pack. Sometimes other people follow the lead and someone who has not cut will say I feel like cutting. It goes with the client age group. A lot are older, 16-18 year olds. They have joined together and tend to feed off one another, follow each others lead.

st - We have competition cutters, the biggest cuts gain the most respect, they want sympathy and respect. But the others, most of them, don't want their peers to know that they've done it, just to be left alone.

c) Types of cutters?

Both young people and staff talked about 'two types of cutters' which bridged the intra and interpersonal explanations. These types were seen as 'serious, sad cutters' and 'attention seeking cutters'. All young people interviewed saw themselves as serious but saw other young people in terms of the two groups.

yp - The copying ones I think are stupid, they're fucking their arms up for nothing. The others I feel sorry for because of the scars. They've got a lot of problems and might think that's the only way to deal with it.

yp - Some of them do it for attention, especially here, but some of them don't. Like they show their arms off all the time and pretend they didn't know they were there. I have a go at them when they do that. Some of them don't cut when they come, then they start. Some of them I can understand and some of them are copying.

st - Abused or fashion. The majority of bad cutters I've come across have been abused girls. Most of the boys I've known it's been quite fashionable, like that pop group.

st - I think there's 2 groups and probably millions in between. The predominant group are cutters who say for god sake do something about this, walking around dripping, with millions of razors. The others who hide it just need to self-punish badly and the longer they go without dressings the greater the chance of infection, which is good for them, takes the self-punishment further.

Several young people highlighted how young people could move between the groups, leading to an inappropriate staff response.

yp - Some people do it for attention sometimes and then when staff think they're doing it for attention, they're doing it because they really hurt.

4.4 EMOTIONAL IMPACT OF CUTTING ON OTHERS

The impact of cutting on others was very powerful and generally negative. Similar feelings were evoked in staff and in young people when their peers cut. More detail was given by staff and their extracts are presented first. Young people found it very difficult to consider the impact their cutting might have on others.

(I) Fear and anxiety

This was experienced by all staff when first exposed to cutting and was related to the shock of seeing wounds and anxiety about the risk of death. Over time most staff reported 'getting used to it' and felt a high level of anxiety only around certain individuals who were cutting seriously.

st - At the beginning I felt shocked and panicky, anxiety that I wasn't dealing with it right. I spent a lot of time with one young woman, 2-3 hours going round and round in a circle and getting nowhere and I learnt a lot from this. I wasn't calm at all, the young woman saw it and played on it.

st - I feel such a high level of concern that I can't think, overwhelmed by my feelings.

yp - I just have to go away, it really upsets me when she does it.

(ii) Sympathy and concern

A small group of staff described powerful nurturing emotions with an urge to protect the young person and this response was described by and observed in the young people.

st - The impulse is to tend to, to nurse, to save, to make better, you've got to look after her, you mustn't be horrible.

st - Sometimes it can be a feeling that I just want to wrap this person up in cotton wool and take their pain away, why is there that need, what are they getting out of it? You know it's about to happen, you get to know them and wish to wave a magic wand.

yp - Sometimes I just sit with them and look after them.

st - Another way young people deal with it is taking control over it...a mirror or parody of what they see staff doing. An attempt to say.. 'I'm looking after her .. we've had a long talk and she's promised me she won't do it again because she knows how much she hurts me'. Feels shallow but an attempt of others to do something.

(iii) Confusion and Impotence

A sense of impotence was universally experienced by staff over repeated exposure to incidents and this seemed to lead to a variety of responses. While some staff expressed anger and frustration, many described feeling cut-off and a general lack of feeling on the subject. Through the process of the interview, many of the staff who were in the 'doesn't bother me camp', acknowledged feeling confused and at times overwhelmed. The

impotence linked to feelings of guilt regarding failing to protect the young people from damaging themselves. In some cases it also led to a powerful staff feeling of being persecuted and manipulated. This theme seems intimately linked to the role of carer.

st - One young person I eventually feel angry with...not aggressive, more..impotent and frightened. What are we doing..we don't seem to be helping. When there's extreme self-harming, all the time, every week, hurts herself significantly, I feel deeply sad about that.self-questioning, wonder what to do. Out of energy towards her, emotional energy, creative energy.

st - It triggered off very powerful feelings for me about my impotence to help this young person. I find she explodes boundaries all over the place..giving bits of information. 'Can I trust you to look after me. I'll tell you something big but you mustn't tell', like a testing out. Needs to know where the lines are drawn, what's appropriate. By the very nature of the job you're looking to help keep people safe. This is patently saying you're not doing it. Sometimes it seems proof of your inability to keep them as safe as you might want to.

st - I've tried a lot of approaches over the years to get to where I am now. Nothing has made a lot of difference

st - When it really does distress me is when I've done individual work with the patient, then go in the next day and find that they've cut all night. Wonder why when they had plenty of opportunity, you feel useless I suppose, 'I've done a lot of good there'.

Young people most commonly expressed impotence by keeping out of others' way.

yp - Leave them to get on with it. Sometimes I say to (young woman) if I see that she's going to cut 'don't do it too badly', there's no point saying don't do it. She sometimes cries after she's done it. You just make enemies trying to stop people.

(iv) Anger

Anger was expressed by staff towards the young people, to the family who was seen as having damaged them and to themselves for having failed to prevent the cutting.

st - Often angry at them 'because you sit there and say just come and tell me when you want to cut. You're angry that you can't help. Sympathy went out the window about 2 months after having come here. You can't make things all right. Almost anger at yourself, you always want to help them more than you can. No one can change a kid that doesn't want to be changed.

st - Furious, enraged, want to attack them further, horror stricken, very frightened and very anxious. Fury is a good one, a part of me is really furious.

st - It makes me feel angry. I feel that I'm being invited to engage in something that has elements of drama and performance and I think my anger comes from my resistance in being involved in this activity. It sets up a bit of a conflict in me. Part of me thinks cutting is motivated by unconscious things which are out of control of the people who are doing it but another part of me thinks that there's something more deliberate about it

which is not about attacking their own internal world or conflicts but about imposing that conflict on the people around them. I think it's something which in my experience always involves an audience at one level or another.

st - There's only one that really gets to me and that's because it's so serious. It brings up a lot of anger in me - 'what the fuck have this family done to her to make her be this way'. Then when she spoke to me about the abuse I thought, her self-harm is nothing, she should be doing something much more than this. It is awful. Out of all of them she is the one I worry most about, she's really there to hurt herself and we haven't had much impact on her.

Young people expressed anger towards their peers by trivialising their cutting. A lot of anger and frustration was also expressed by young people and staff about the contagion of cutting. Young people felt that the copying or catching of cutting trivialised their feelings and universally desired that other young people would not be influenced by their behaviour.

yp - It really pisses me off because they just want attention.

yp - Some of them cut their arms because others do. I don't know whether they think it's a way of getting attention because you don't get much attention. It really annoys me, makes me angry. It's like when one person does it they all have to do it. They think I'm in here being asked what's up. I'm not, I'm being bloody shouted at. It's not a good way to get attention, they should know that.

(v) Cut off

This theme generated a lot of discussion across the staff group and was seen as a vital and generally positive coping response necessary for surviving the work.

st - We don't have normal reactions at all. It's quite worrying how we've managed to normalise this. They come to you, you wrap them up in bandages and it's like serving dinner. Every new staff who comes in, they're traumatised for 6 months and then it's like serving dinners, then you make jokes about it. It's a coping mechanism, that 10-15 year olds are slicing up their body and you can't do anything about it. The younger the cutter the harder it is. 'Brain meltdown', laughing is the only positive way to cope with this. Anger is well-buried. You have to learn to cope, to say it doesn't bother me. You can't crack up every time a kid cuts, whilst you're cleaning up you might be restraining in the next 10 minutes. You can't afford to feel anything.

st - I don't ever feel uncomfortable about self-harmers, have to stay detached personally. It used to scare the life out of me, gaping wounds. Now it doesn't affect me in the same way, horrible sight but you just deal with it. If you get emotionally involved in the whys and wherefores of what goes on you're going to crack up. We need to be strong for the kids.

Young people frequently said they didn't feel anything when others cut.

yp - It doesn't bother me, I just keep out of the way, let them get on with it.

4.5 RESPONSES OF OTHERS

This section is divided into (a) staff responses to cutting and (b) young people's experience of responses.

a) Staff responses to cutting

As would be expected, staff responses depended to a large extent on the explanations attributed to the behaviour and personal feelings evoked. Broadly speaking staff responses could be placed on a continuum from a practical care/ repair response through to an intense engagement which at the extremes took the form of a rescuing response. The impact of the behaviour on the staff group often divided opinion and anger was expressed towards those who took on a different view.

(I) Practical care/repair

Staff expressed a sense of relief around the process of cleaning up. This paralleled the relief described by young people when emotional pain was made definite by cutting. Practical care also at times represented the minimum care possible with some staff believing that the behaviour should be ignored but that cleaning needed to be done.

st -I can deal with it afterwards, clear it up, you can mend what's been cut, can see it to deal with it. I can sit when a girl's cutting or whatever, I have sat with a girl who tried to cut her throat with glass, or someone who put a razor blade into their veins and got it under their skin. I don't like over dosing because I can't see it to deal with it. You can patch up, clean cutting.

st - There's something nice about cleaning people up. A lot of our job is very grey. It's quite nice sometimes to do something with them, clean them up, nicely bandaged arm, then they might trust you enough to tell you why.

st - I normally clean up first, but don't like to reinforce the behaviour so just respond with the medical stuff and go and fill the incident form.

st - Some staff have said they're quite rough with people, when stitching them up.

(ii) Engagement/ Rescue

This response seemed an attempt to understand the young person as far as possible and in some cases to 'make up' for past experiences of poor care.

st - To be there or when they tell me to show warmth. Try to be supportive and empathic about how they're feeling. Check it's clean and covered, bandaged or whatever. Lot of concern around. I often pick it up later with them. They can spend time reflecting how they feel, for example, write about it. Let them know we're there to work through that with them rather than wait until they do it again.

st - I think it's all part of the process the young women are going through. It can be very painful to sit down and watch a young woman do that to herself but for me it's about trying to stay with that. Talk them through that until they're able to say 'I've done enough' and are able to hand pieces of glass or whatever over. I'll stay with it if I'm

needed. I'd rather sit with them when they do it than let them be on their own. I don't enjoy it .. it's pretty horrible watching them, especially when it's quite deep.

(iii) Staff conflict of opinion

Strong negative feelings were expressed by staff towards colleagues who responded in contrasting ways.

st - Sitting up and talking for long periods of time is bad, it ends up in a pattern. There's something in it for the staff who do that. For example there's a staff member attached to one girl who has done a lot of work with her. She would sit for hours with this young woman. It's not healthy, then the staff are like kids too. I'm very good at settlingat bed times, and bed time is a difficult time. They know the routine with me. But one night because this member of staff was there, she sat talking with one girl and they weren't going to bed. She said she wants to replace the abuser. But I said she's here for all the girls, not just one. Now when this staff member is on the girl feels she can act out, put food on her. I knew it would backfire but the staff member gets so upset when the girl is angry with her. I sit there and I think 'what the bloody hell are you getting out of this?' I care about the girls but then I back off. If they give me a hug I don't like, I'll tell them it doesn't feel good. I'm here to look after the girls but not to re-enact abuse. Getting sucked into relationships is abuse. I don't worry about the girls. I worry sometimes about the staff.

st - Brings different opinions out in the staff group. Some people define cutting as attention seeking behaviour. I personally dispute that. My opinion is that it isn't

attention seeking behaviour. This does cause problems among the staff. I may get angry with the person but not because it's attention seeking. There's conflict with other team members about whether people did the right thing.

b) Young people's experiences of responses

The young people gave a variety of differing and often contradictory views which seemed to encapsulate the ambivalence of being cared for as an adolescent and specifically an adolescent in a 'care' situation.

(I) Ambivalence about being cared for

A desperate desire to feel cared for was often combined with a desire to be left alone and to take responsibility for themselves.

yp - Good that staff talk to you .. shows how much they care doesn't it? I want them to talk to me when I'm calmed down, not straight away, just want them to leave me for a while. When I'm stressed I want to be on my own.

yp - We need space. In a way I want someone there with me to protect me but then again I want a bit of space.

yp - Nothing. I just want them to leave me alone. Piss off and get out of my fucking way. Or let someone I like sit with me for a little while.

A few young people were able to verbalise how they understood this conflict of needs, that feeling care was intensely frightening and made them vulnerable to the feelings that they were familiar with.

yp - One of the characteristics of people who self-harm is that they have the capacity to worry about other people but can't about yourself. eg. (young woman) looks after other people but is abusive when people try to look after her. I feel abusive too because you feel they shouldn't like you or care about you, it's also like extending your family, more guilt. In a 'hate world' it would be easier.

yp - They wouldn't leave me alone and that really pissed me off. I had to give the glass in otherwise I wouldn't be allowed in my room. Staff stayed with me till I was asleep and that pissed me off even more, because I'm not used to people caring that much and it scares me when they care because I think I'm going to get hurt.

(ii) Staff don't care and punish you for your feelings

Another strand of experiences was focused on a profound feeling of not being cared about. This was expressed by the view that it would be better if staff don't know and that staff could never really care properly as they were paid to do their job.

yp - I listen to what people say time and time again. Even if people say good things I don't feel it. I'm fighting with myself. It's like I feel they're saying what I want to hear and that they don't mean it. Like I said to (member of staff) that I felt awful and that I cared about her and she wrote to me then but she wouldn't have thought of it. It's like

being a page in people's diary. But I suppose no one is dumb enough to look after me unless they're being paid for it. I don't think anyone would do it unless they were being paid to do it. It drives me to insanity.

Several young people gave examples of staff behaviour which showed them that not only did staff not care but that they felt angry and punishing towards the young people.

yp - Sometimes when someone runs off and they get stressed they take it out on one of the other kids. When staff are having a bad day they make everyone else's day bad. It is a punishment, being punished for the way you feel. When they strip the room they search everything and dump it in black bags. They don't do it neatly. If it was to keep us safe they would make sure there's nothing there and if they find something lock it up, they would leave your belongings. Locking up your belongings is a punishment.

yp - I just feel that if some of them have been threatening themselves, it's hard to get people to listen. They just don't want to know, say it's a waste of their time, that we're playing games. This word 'play games' makes you feel even worse. So you think 'I've just cut myself up so you can have a laugh'.

(iii) Do nothing

All young people described impotence in the face of what might be done that would help and many acknowledged that often there was nothing that could be done other than practical care. Many young people saw their cutting as nothing to do with anyone else.

yp - Try and steri-strip it, dress it. Just the practical nursing thing, open wound, wrapping it up. Other than that people don't really know what to do. There's not much else they can do. If I wanted to stop I suppose they could help

yp - When I cut I don't want anything, leave me alone, go away. If they tried to stop me I'd cry and shout at them. I feel the same way afterwards.

yp - Never want others to know, wish everyone would just leave me alone.

yp - Nothing, leave me alone.

(iv) Accept/normalise cutting?

Most young people felt strongly that staff should accept their cutting as normal and reasonable behaviour but references were also made to how non-acceptance was experienced as genuinely caring.

yp - Don't know. I just want them to help me feel normal, then I wouldn't have to display my outrage at not being. Just understand.

yp - Everyone's got a right to do what they want.

yp - I want to try and beat it myself. Not sure if I want to stop. I definitely want to stop where people can see because then so many people can't empathise with it, they see scars and see you like an alien and to some extent you are.

yp - Sometimes I can't believe that they bother so much and when they took my aerosols away I thought the staff do care about me.

(v) Prevent serious damage

A final theme expressed by almost all young people was around their hope and expectation that they would be protected from doing serious damage to themselves.

yp - Here they're not allowed to physically stop you unless you're doing something completely insane. But in hospitals they're there to stop you .. a bit of relief that someone can stop you and at other times you just wish they would bugger off. Sometimes you have control and can stop .. but other times you just wish someone would stop you because you can't stop.

yp - They should stop people if they're doing serious damage but if doing superficial cuts, no. Staff should watch them .. check they're all right. Staff could walk away if you're doing really deep cuts and then come back and find they're dead. I've had staff sitting in here when I've been cutting. You can't stop someone from cutting.

4.6 SUMMARY

Although many explanations were idiosyncratic, there was much overlap between the categories that emerged and a high level of consistency in the accounts. Intrapersonal explanations for cutting predominated for both young people and staff. Young people in

particular saw cutting as an internal process which was largely unrelated to the impact it might have on others.

The interpersonal explanations became more apparent when people talked about emotions evoked by cutting and their responses to it. Apart from the category of cutting as a way of ‘punishing others’ which was not mentioned by young people, there was agreement that cutting was sometimes used as a communication and to engage staff and gain status. It is significant that young people saw the last two as applying to their peers and not to themselves.

Powerful feelings were evoked by the cutting. There was a pull towards polarised responses with staff coming into conflict with colleagues over contrasting approaches. The responses were justified by the explanations attributed to the cutting and both young people and staff divided ‘cutters’ into two broad categories, ‘sad’ and ‘attention seeking’.

Young people’s experiences of responses to their cutting were often negative and a great deal of ambivalence was expressed.

4.7 SUBJECTIVE EXPERIENCE OF INTERVIEWS AND FOLLOW UP

DISCUSSIONS WITH PARTICIPANTS

The experience of carrying out the interviews and discussing the ongoing analysis with participants adds understanding and will be briefly described.

Subjective experience of interviews

The interviews with the young people were quite overwhelming. The depth of despair communicated, in particular relating to their experiences of staff responses, highlighted how profoundly uncared for the young people felt. At times they found it hard to describe their experiences verbally. My role as researcher seemed to facilitate the young people's expression of their experiences and at the same time evoked powerful feelings of impotence in me. Moving between young people and staff interviews was especially stressful as I found myself feeling polarised and drawn into the young people's perception of staff as insensitive and punitive. This was in spite of my understanding that staff need to protect themselves from being swamped by unbearable feelings.

In the staff interviews I felt highly motivated to explore their feelings about the young people and was surprised and at times frustrated at resistance to thinking about this. When I asked about this it appeared that some staff felt that expressing negative feelings was wrong and communicated a sense of shame.

As the interviews progressed I found myself impatient for them to be completed and found it increasingly exhausting engaging with the young people's distress.

Young people said they found the interviews hard, at times feeling quite agitated, but most were pleased that an adult was seeking their views. Staff all reported finding the interview engaging and commented how helpful it was to think about their feelings.

Discussions of analysis

A sample of 3 young people and 3 staff discussed the analysis with the researcher as it progressed.

Young people thought the summary (Appendix X) was a faithful representation of their experiences and raised two main issues. One young person thought the category of ‘getting bad things from the inside to the outside’ was misleading because it was not possible to get bad things away or out of the young person in spite of all attempts. It was explained that the bad things remain on the person, in the form of the cut.

The issue of the ‘attention seeking’ category raised discussion. Two young people agreed with the category but maintained, even after some discussion, that it did not relate to them but only to their peers. A third young person said that ‘attention’ was so negatively connotated by staff that no young person would want to relate it to them. She expressed a lot of anger about society dividing people into simplistic groups which diminish the individual’s unique experience. She thought that the term ‘attention’ was used to punish what she saw as ‘seeking care’ which should be acceptable. She thought that young people do sometimes cut to punish staff but that they wouldn’t acknowledge it because of the negative feelings that it brought up in them and also that they received from staff.

Staff members were very interested in the analysis and expressed some surprise at the extent of lack of care articulated by the young people (Appendix XI). They also talked about how in some ways working with cutting becomes more painful over time as the extent of the young person’s anguish or damage becomes clearer. This was related to a

sense of disillusionment in the ability to help which raised painful issues for some staff. They clearly recognised the 'rescue' versus 'withdraw' response in themselves and colleagues.

5.0 DISCUSSION

It is clear that cutting is a complex phenomenon which may be understood and explained at multiple levels. There was a high level of consistency in the data and all participants referred to intra, and interpersonal processes. There were parallel processes in the young people and staff groups which was unexpected as it was initially thought that young people and staff perspectives would be contrasting whereas the range of views was represented in both groups. The range of views also spanned setting and gender. While it is not possible to make statements about gender due to the small number of males, the young men gave similar accounts to the young women and it appears that the categories that emerged are independent of setting.

The main area where differences were clear was where staff and young person were in carer and cared for roles. The role of 'carer' appeared to have a strong influence on responses. A number of unstated assumptions emerged, illustrated for instance by the difficulty staff experienced in acknowledging negative and aggressive feelings towards those in their care.

Many different approaches can be used to understand the way that people develop beliefs and understandings about the world which Hoffman (1990) has described as looking

through different lenses. Behavioural and psychodynamic approaches to understanding are examples of possible lenses. Social constructionists posit that evolving sets of meanings emerge from the interactions between people and can be seen as a 'lens about lenses'. Many different articulations of meanings, explanations, beliefs and justifications emerged in this study and this discussion will attempt to explore them and relate them to the current literature.

Intrapersonal explanations for cutting predominated, as a coping strategy for overwhelming internal experiences and in response to beliefs about lack of self-worth. Cutting was clearly seen as a way of managing life rather than as about dying and was experienced at times as an invaluable coping strategy. The self-hate/punishment category explanations were particularly stark and a profound level of despair was communicated, *'it's like there's nothing inside'*. The theme which appeared to encompass the intrapersonal explanations was that of converting emotional pain and confusion into something definite in the form of a cut. The young people communicated a sense of powerlessness in the face of unbearable experiences which was concretely and symbolically represented by the cutting, *'it's hurting somewhere else but it doesn't hurt your soul, your heart'*.

The interpersonal explanations emerged around communicating the level of distress, punishing others and gaining status and attention. Staff however attributed the processes as happening solely inside the young person, such as their desire to get back at staff, and so these explanations could be considered as quasi-interpersonal. More fully interpersonal processes related to responses to cutting, where the emotional impact of cutting was described, acted upon and the young people's experience elucidated.

The emphasis on the intrapersonal that was articulated may arise for a number of reasons. It reflects the dominant cultural framework of our time and it was striking that the explanations were almost exclusively psychological. Biological and social factors were rarely mentioned. Locating the problem within the young person may allow the individual to take on a patient role and enable staff to locate all distress and responsibility within the patient. Smith (1995b) describes how through repeated interaction with others, interpersonal connections can be translated into intrapersonal beliefs. So, for instance, a young person may cut for a range of poorly defined reasons and receive a negative response from others, such as *'you're only doing it for attention'*. Over time the young person may internalise the experiences of not feeling listened to and there being something wrong with them and articulate a sense of themselves as *'an alien'*.

In general the impact that cutting had on others was negative. Feelings of anxiety, anger, distress and impotence were described. All young people said that they didn't want their behaviour to upset others as this made them feel worse but they had the experience of staff communicating their negative feelings and their own negative reaction when others cut. There appeared to be great difficulty in integrating the conflicting and confusing experiences into a single account of what might be occurring.

The process of separating people who cut into two groups, 'sad cutters' apparently deserving of care and 'attention seeking cutters' who should be ignored was very interesting. Dividing the groups seemed to provide clarity and enable the negative experiences evoked when young people cut to be distanced from the powerful

communication of need and distress. Staff responses tended to become polarised and justified in terms of the motivation attributed to the young person. Young people also divided the groups but always placed themselves in the 'sad' group. They communicated a sense of connection with a few other people who cut, those that seemed like them, but clearly distanced themselves from those who they saw as 'attention seeking'. The process of the young people distancing themselves from the 'attention seeking' and 'punishment of others' explanations appeared to be influenced by the highly negative connotation linked to these categories.

It is interesting that imitative behaviour, '*copycat cutting*' was equated with '*attention seeking*' and, hence, viewed entirely negatively. Imitative behaviour does not necessarily involve dynamics with staff but may relate to peer group processes of seeking intimacy through alliance which was rarely mentioned (Walsh & Rosen, 1988). Similarly, although cutting was seen as a negative behaviour, young people talked of it being an important coping mechanism and staff described it as a means for engaging with young people and finding relief in the concrete and definite process of cleaning.

The process of making things concrete or definite which was represented in the act of cutting and in the 'repairing' response was also apparent in the labelling of young people. Examples such as '*abused or fashion cutter*' illustrates how the individual is equated to their behaviour with limited possibilities of identity conceptualised. Several young people said it was better to cut than to be violent suggesting that harm to the self or to others are other role options with organisational consequences '*I cut because if I'm violent I might get thrown out*'.

Cutting was consistently defined by *'blood running'* and *'making a scar'* and was distinguished from scratching which was seen as less significant. Since, however, all young people saw themselves as *'real cutters'* regardless of severity, it is not clear how far the distinction links to the young person's experience of the act or to staff responses and perceptions of *'what counts'*. Anxiety in others increased with more serious damage and it seems likely that this would have an impact on the perceived status of the act. A broad definition of cutting was, therefore, accepted since references young people made to cutting were likely to include both *'cuts'* and *'scratches'*.

Lastly, the role of carer appeared to be central. The articulations of the need to 'rescue' and powerful feelings of impotence evoked when the person failed to respond points to wider issues of role perception and an inflated perception of influence in the carer. The issue of who wields most power or influence in the context of cutting is complex and in fact both groups articulated a sense of helplessness, that *'staff never have time to listen'* and *'nothing I do makes any difference to whether they will cut again'*.

5.1 DEVELOPING A MODEL

Given the consistency of the data, this section attempts to link and develop the categories and move towards a more theoretical understanding. The participant accounts are used to map out a sequence of events that occurs around cutting, drawing together the explanations and beliefs inherent in the accounts. This involves extrapolating from the data and assumes that the accounts point towards some 'realities' about what is occurring. The

emerging model will then be related to the literature. Since most material involved intra and interpersonal processes, these will be considered in some detail.

Linking of categories

The task of linking categories can usefully start from the individual experience and work outwards. A central theme that permeated the study was the way in which unbearable experiences are managed.

Intrapersonal cycle

Cutting could be seen to serve a number of intrapersonal functions for the young people, primarily aimed at establishing a distance from unbearable experiences. Acting on conflicting feelings by cutting may provide a temporary solution by fulfilling the functions outlined in the intrapersonal categories, relief and distraction, self-punishment and internalising anger. A short-term cycle appears to be operating whereby the various functions are partially fulfilled leading to a less overwhelmed state in the young person. This cycle may be self-maintaining.

The explanations that emerged are consistent with the young people's view of themselves. They had damaging experiences in childhood, were separated from their families, and communicated a sense of themselves as desperate for care but also as unlovable. The internal resources available to them to express their needs were limited and inadequate. In the face of underlying vulnerability, the young people were frequently overwhelmed. It appeared that they found themselves unable to communicate their distress verbally and felt

compelled to do something. Damaging themselves, therefore, provided relief on many levels.

The link between the intra and interpersonal explanations appears to involve the process of making distress concrete and on the outside of the body in the form of a cut which moves the behaviour into the public arena and has an interpersonal impact. It could be argued that this is the case whether or not the cuts are shown to or known about by others since there is a strong sense that others should be protecting the young person from harm and that, therefore, an audience is involved. The young people showed a high level of ambivalence regarding whether they intended others to know and often communicated it via many contradictory actions.

Interpersonal cycles

The staff appeared to be aware of the majority of incidents of cutting. While staff may be aware of the turmoil and distress of the young person, high levels of distress are often difficult to engage with and most staff found the confusion around cutting intolerable. There was a strong pull towards staff members becoming polarised in their views and responses. Two interpersonal cycles could be identified. These cycles related also to young people when their peers cut.

Rescue

The accounts suggest that when staff first encounter cutting they feel anxious, often fearing potential death of the young person. They engage intensely with the young person with the unstated aim of ‘rescuing’ them through understanding and care. This response is based

upon the staff member's sense of themselves as a carer, their task being to protect and nurture those in their care and a sense that they should be able to influence the young person. The young person may feel hopeful and cared about for a short time and an intimacy may develop. Further events or anxiety about feared loss, however, lead again to the young person feeling overwhelmed. The next incident of cutting can be interpreted as proof of a failed rescue by the staff and staff may experience powerful feelings of failure. The cycle of staff anxiety leading to attempted and later failed rescue may continue for some time but culminates in frustration and an experience of impotence. Feelings of anger are experienced which are directed towards the young people, past abusers or the staff member themselves for their failure.

Withdraw

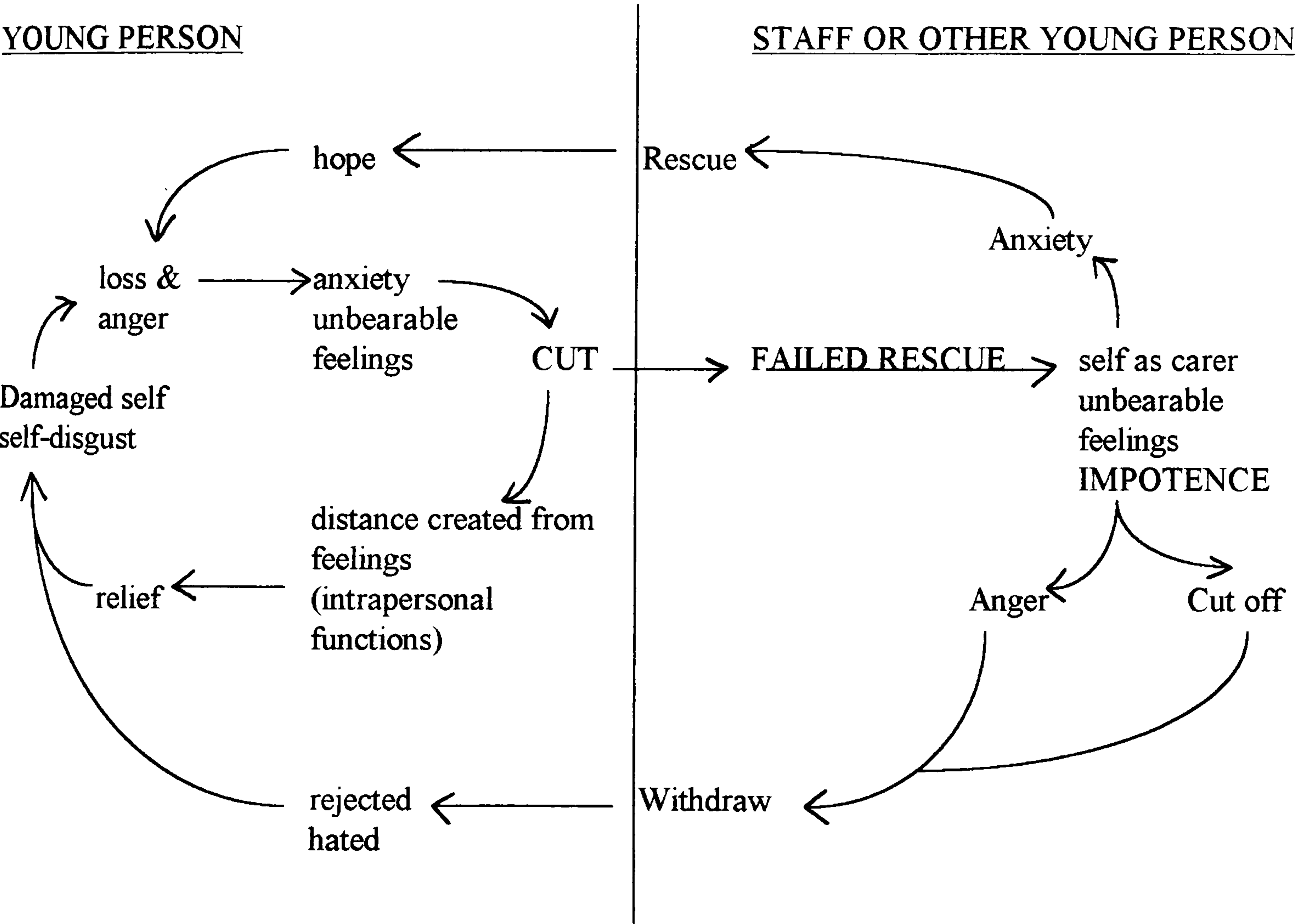
Over time and with repeated failed rescues it appears that a different cycle comes to the fore. This involves staff withdrawing or disengaging from the feelings aroused by failing to prevent the cutting. In this 'cut off' frame of mind the accounts indicate that staff attribute all feelings to the young people who are experienced as beyond help, manipulative and tormenting to staff. Staff responses tend towards practical care which is carried out with minimum emotional engagement. The young people may respond by feeling rejected and hated leading to powerful feelings of anger and loss which cannot be managed internally and the person may cut again.

It appears that engaging in practical care is satisfying for staff as they have a definite and achievable task. Although focusing on this task may feel helpful and manageable to staff it is argued that staff effectively disengage from the complexity of the young person's

communication and are operating within this ‘withdraw’ cycle. Normalising cutting can also be seen as withdrawal by denying the self-destructive nature of the behaviour of which young people are often acutely aware.

Figure 1 below illustrates that a combination of intra and interpersonal cycles appear to be occurring that may become self-maintaining.

5.1.1 Figure 1: Intrapersonal and interpersonal cycles involved in cutting



There is a powerful sense of repetition in both the intra and interpersonal cycles. Figure 1 represents the main polarised responses that appeared to be occurring but obviously many day to day interactions and responses would not fall at the extreme end of these poles. The

term 'loss' illustrated in Figure 1 includes feared loss and memories as well as actual experiences of loss or rejection.

Wider issues

In addition to the above, a number of group processes were highlighted. The contagion of cutting evoked powerful negative emotions from both young people and staff groups. Staff saw contagion of cutting as arising from jealousy over staff attention to others and as a peer game to attain status. Both explanations diminish individual experience and trivialise the level of distress. Young people felt angry with contagion for similar reasons. They were, however, unable to see themselves as involved in cutting for attention and status and became enraged when it was implied by others. This may be because these explanations attract highly negative connotations which may link to aggressive feelings in staff. The contagion explanations made little reference to processes of joining and finding intimacy within the peer group.

The process of categorising people who cut into two groups, 'sad versus attention seeking cutters' was striking. With reference to Figure 1, individual young people may be identified as operating primarily within a particular cycle and then related to in these fixed roles, for example as either victim or aggressor. Conflict within the young people and staff groups often revolved around different opinions over this issue. On reflection all agreed that the situation is more complex and fluid than this but that lack of clarity is difficult to manage.

A final level of understanding moves towards societal issues including expectations about carers and 'abused children' and issues of power and influence. The conflict arising within

the staff groups was expressed through anger towards staff who were seen as punitive or abusive in their responses. This operated in both directions which suggests high levels of ambiguity and insecurity in the caring role in this context. Links may be made to individual staff members' histories and sense of themselves as carers and societal expectations that carers are 'good people' who are warm and nurturing. Through their explanations staff communicated views of carers as people who do not or should not experience conflicting and negative feelings towards those in their care and who will protect them from harm. Staff appeared to integrate their feelings and responses into an explanation of 'good care' so that all responses could be explained as consistent with a benevolent role.

Cutting appeared to connote failure of care. Young people not only harm themselves but staff experience conflicting and often overwhelming feelings towards those in their care and a process of blaming can easily come into play.

It is apparent from the discussion above that issues of power and influence are central to cutting at all levels. Cutting not only appears to lead to staff experiences of inadequacy but often compels a staff response through their obligation to try and keep the young people safe. The use of the body as a means of gaining power may be linked to finding sources of influence in contexts where individuals have minimal power, for example in prisons with the use of the body to protest and in the use of the female body as an object.

Figure 2 on the following page illustrates the multiple levels which may be influencing cutting behaviour. Many social factors such as the idealisation of the role of carers, dominant views of adolescents and gender, ill versus healthy people and structural factors

around class, health care policies and organisations may be impacting on the smaller system. The ways in which meanings are negotiated and implemented in local conversation also constructs and maintains ways of seeing roles, and for instance ideas of rescue, blaming and pathologising. It was striking that the accounts articulated by participants were predominantly psychological with few references to social factors.

5.1.2 Figure 2: Multidimensional factors involved in cutting

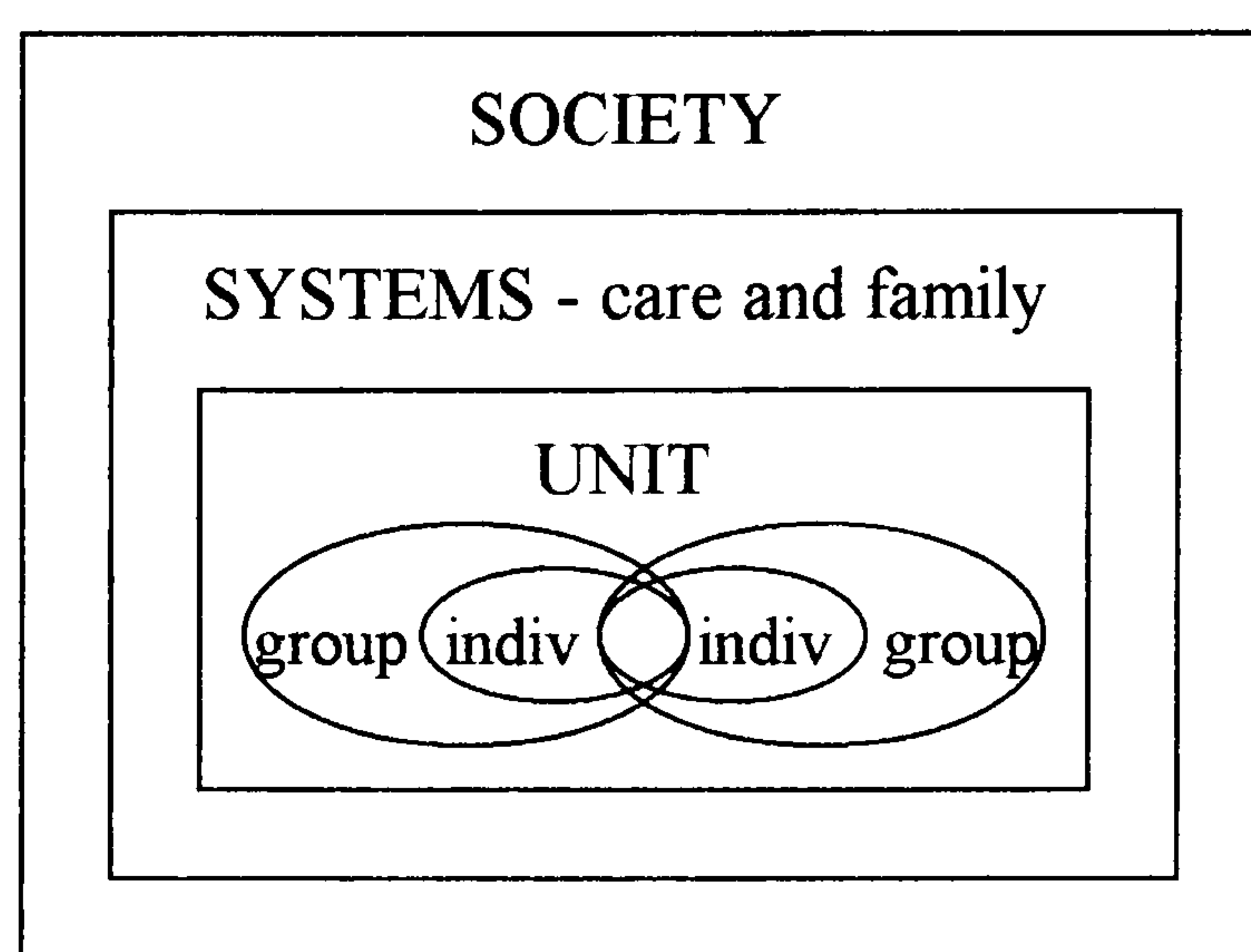


Figure 1 represented only the central feature of Figure 2 which highlights the complexity of the processes which may be involved.

A number of higher order categories can be drawn out which can be seen as overlying the categories in section 4.0. Damage is evident at many levels, in the damage caused to the body and to relationships. The explanations and categorisation that occurred seemed to be an attempt to make definite the confusing and overwhelming experiences associated with cutting. People appear to become fixed in their thinking and roles which can be characterised by rigidity rather than flexibility. The ‘failed rescue’ cycle that was outlined above appears to be central and strikes at the heart of the helping relationship and the personal and societal issues involved.

5.2 RELATING EMERGING MODEL TO THE LITERATURE

The findings will be considered first from an intrapersonal perspective and then broaden out.

Intrapersonal

The current findings are consistent with Favazza's (1989) view of cutting as intentional and designed to provide relief for experiences that cannot be managed in any other way. The intrapersonal meaning and functions of cutting that emerged in this study are consistent with the first two of Allen's (1995) categories for cutting, as a way to manage moods and as a response to intrinsic beliefs. Suyemoto and MacDonald's (1995) explanations for cutting would also be consistent with the intrapersonal cycle that emerged. Tantam and Whittaker (1992) suggested that the desired alteration of mood might take place via biochemical mechanisms, through conditioning or symbolically. The intrinsic beliefs of the young people centred on lack of self worth which is consistent with analytic literature which has stressed the underlying fear of abandonment and feelings of powerlessness, anger and dependence in people who self-wound (Feldman, 1988).

Given the frequent histories of neglect and abuse of people who self-harm, a number of researchers have noted that people who cut have not had reliable experiences that their expressions of need produce an appropriate response (Doctors, 1981). Sarnoff (1988) suggests that this leads to a lack of mastery of symbolic communication and that cutting is used as a "primitive evocative symbol which may discharge the feeling but does not

effectively communicate it, distance from it or obtain mastery over it” (p53). This would fit with the findings that repetition of cutting becomes addictive (Tantam & Whittaker, 1992).

The intrapersonal meaning and relieving function of cutting is evidently an important aspect of cutting, but this study has highlighted other processes that appear central in residential settings. “Disturbed behaviour is produced by disturbing situations or disturbed relationships as well as by disturbed personality” (Tantam & Whittaker, 1992, p54) and the former have been systematically neglected. As raised in this study, the young people’s sense of themselves is influenced by the nature of the local interactions with others that constructs and maintains ways of seeing their roles.

Interpersonal

The most striking finding was the tendency for staff to become polarised in their thinking and responses. As raised earlier this appeared to be related to difficulty in developing an account which integrated the conflicting and confusing experiences. The act of cutting has the advantage of being able to simultaneously convey irreconcilable ideas such as the desire for comfort and also for retribution when the person experiences a sense of lack or need (Hartman, 1996). Watzlawick (1978) suggests that interpersonal cycles become maintained by self-fulfilling perceptions, beliefs and feelings.

Psychodynamic theorists provide an account of unconscious interpersonal communication which appears relevant to the above and will be briefly outlined. Halton (1994) discusses how people often find it impossible to put their experiences into words and re-create their experience via the communicative process of projective identification. Internal conflicts,

such as feelings of love and hate for the mother/carer, cannot be managed and the unwanted feelings are located, or projected, into others. This emotional conflict can also be acted upon, for example by cutting, so that conscious remembering of emotional conflict is replaced by action (Norton & Dolan, 1995). The recipient then “reacts to it in such a way that their own feelings are affected: they unconsciously identify with the projected feelings” (Halton, 1994, p16). A complementary style of interaction can develop whereby staff provide a symptomatic response which represents one part of the person’s conflict as illustrated when staff respond to the young person as either the victim or the perpetrator.

Ogden (1982) describes how a failure to adequately process the unconscious communication results in the therapist responding in one of two ways “either by his mounting a rigid defence against awareness of the feelings engendered, or allowing the feeling or the defence against it to be translate into action” (p32). An interpersonal enactment then takes place between person and staff which can be seen clearly in the current model. Tantam and Whittaker (1992) suggest that the impulse to save patients is as potentially destructive to the person as withdrawing and that both responses are likely to ignore the person’s needs and concerns.

The account presented above is very helpful in addressing the complex processes occurring in both young people and staff groups and goes beyond purely individual explanations. It does, however, still reflect the dominant mode of understanding ‘dysfunction’, that is by a process of pathologising the ‘patient’.

Adolescent developmental issues of separation/individuation and identity development were raised in the introduction as important issues regarding cutting. Wilson and Farquharson (1996) describe how adolescents, whose early experiences of relationships were insecure and damaging, are more likely to have difficulties establishing a sense of themselves as separate and that much disruptive behaviour can be understood as an attempt to register contact and involvement with others. As a result of early deprivation they are caught between longing to be cared for and intense feelings of hostility to those who may provide care. In the current study both young people and staff described difficulties in establishing a bearable sense of closeness, for instance young people feeling left and staff feeling smothered. The therapeutic goal of addressing these issues involves the adolescent negotiating closeness and distance in their relationships. Woods (1988) describes how the intense closeness that comes about as part of this process, often referred to as merging, raises anxieties in both parties that they will be lost in the intensity of the experience. It may be that cutting serves distance regulating functions.

Wider issues

Difficulty in achieving intimacy in relationships has been linked to the contagion of cutting as cutting often has the short-term impact of drawing people closer (Walsh & Rosen, 1988). In the current study the impact of the peer group was referred to when participants talked about 'copy cat cutting'. Walsh and Rosen (1988) highlighted the more positive aspects of group processes and discussed how pressure can build within some settings for individuals to self-mutilate to gain acceptance and to show support and nurturance to others in crisis. It seems important that the more rewarding aspects of the cutting process remain in awareness.

Tantam and Whittaker (1992) raise the aspects of violence and aggression inherent in the act of cutting, “like an attack in which the blow falls not on the victim but on the attacker” (p460). The violence is primarily experienced by the young person through self-abuse but is also experienced by staff. The staff experience seems to link centrally to the sense of themselves as a carer. The tendency to see the person who cuts as a victim may protect others from experiencing the aggression towards them. These feelings are experienced nonetheless and communicated covertly by, for instance, the pejorative and dismissive use of terms like attention seeking.

A number of authors, notably Winnicott (1947), have described how carers experience strong negative feelings when their care is rejected which may then lead to blaming the person being cared for. With reference to the model presented in Figure 1, this process can be seen to be operating when carers experience rejection and impotence and then become angry and ‘cut off’. From a psychodynamic perspective Menzies-Lyth (1988) has elaborated on carers intense emotional responses and has described the way in which caring institutions can organise themselves to avoid intimate contact with those in their care as a way of containing anxiety.

Wider societal expectations may be limiting the role options for young people and staff. The expectation that carers should feel warm and nurturing to those in their care has already been alluded to. With respect to the young people, it appeared that being a ‘cutter’ was often equated with their identity. Potential roles include being seen as a victim or aggressor and some accounts pointed towards cutting as a way of managing anger towards

others. It may be that cutting is sometimes used as an alternative to violence as a way of managing placements. This polarisation of roles has been noted by Bentovim (1992). He suggests that following the experience of trauma and powerlessness inherent in abuse, individuals may respond actively through identification with the abuser leading to violence or may respond in a 'victim' mode.

Cutting is an act which brings issues of control and influence to the fore. In all relationships various attempts are made by individuals to influence the other person, whether overt, covert, deliberate, non-deliberate, conscious or unconscious. The individual's contribution depends on their personal experience as well as the power inherent in their designated role. The relationship between issues of power and psychological symptoms has been explored in the recent literature regarding sexual problems (Dallos & Dallos, 1997; Foreman & Dallos, 1992). Some writers believe that relationship problems are primarily struggles over power and that wider societal constructions and beliefs, for instance regarding gender, become woven into the individual's belief system (Madanes, 1981). Feminist writers have emphasised the importance of taking an external perspective on power, looking at the wider societal contexts that are influencing the smaller system (Goldner, 1991).

With reference to the current study there are fundamental inequalities of power between young people in care and staff. In addition to societal beliefs, whereby children and people who are unwell are accorded less power than so called healthy adults, children in care are also constrained by the constant possibility of being expelled from a placement if their behaviour exceeds certain limits. The latter appears to be significant in the young people's

choice of cutting rather than violence. While a host of intrapersonal factors may predispose particular young people to harm themselves rather than others, there are also external factors, principally communicated through staff attitudes and communication, that cutting is more acceptable than violence. Menninger (1990) highlights how overt hostility from clients is particularly anxiety provoking for clinicians and staff participants confirmed this.

Cutting is paradoxical in that it tends to evoke intense activity in staff, providing a temporary experience of power and influence in young people, yet the consequences frequently involve increased restriction. The situation is complex since it appears that the rejection or failure of care is difficult for staff to manage so that cutting may provide a potent means for young people to influence those around them, as well as themselves. Staff also have limited power, being constrained by external factors such as the law and also painfully aware that despite all efforts it is impossible to prevent someone harming themselves. The high prevalence of self-harm in enclosed institutions such as prisons illustrates how the body can be used to influence others or protest in contexts where individuals have minimal power (Inch et al, 1995). As stated by Foucault “The agency of domination does not reside in the one who speaks (for it is he who is constrained) but in the one who listens and says nothing” (1978, p61).

5.3 CRITICAL REVIEW

The current study will be reviewed before discussing research and clinical implications and concluding. The methodology of the study will be evaluated according to the areas

outlined in section 2.1. These were openness, replicability, grounding, verification and uncovering (Barker et al, 1994).

Considerable attempts were made to adopt a reflexive and open approach during the study which included keeping a diary throughout and referring to the various influences in carrying out the research. The authors previous experience in residential work appeared to have an impact on the interviews. Young people appeared to relate to me as an adult who was interested in their views but initially some communicated that I might take more notice of staff opinion. During follow-up meetings the young people became increasingly involved, asking questions and making suggestions which were integrated into the study. Some staff appeared anxious about potential criticism and it was clear that my communication of experiencing similar dilemmas and difficult feelings had a significant facilitative impact. Similarly it appeared helpful that I was relatively unknown and coming in from outside the organisations in a spirit of enquiry.

Replication of this study could be attempted since the procedures are clearly described but it seems likely that different researchers might be interested in pursuing different dimensions or aspects of the area. The concept of an audit trail to allow others to check the process of theory generation and interpretation therefore seems more helpful. Drafts of the analysis and emerging model were shared and discussed with a number of colleagues with this aim in mind. During the process of the research I found myself repeatedly drawn towards psychological and specifically psychodynamic accounts of the processes. This illustrates how my previous experiences and interests may have coloured the interpretation

process. As discussed, however, many attempts were made to elicit feedback from others and different schools of thought were drawn upon to interpret the data.

A number of methods were used to check the validity of the results, namely the participants checking the transcripts and being involved in ongoing discussion and a number of researchers checking the results against the data. The former was particularly illuminating and indicated that further discussions with participants would have been valuable to pursue confusing or new information. Repeated discussion of findings with participants was a challenging process as inconvenient data could not be ignored and it led to a strong feeling of commitment to participants views which seems entirely appropriate and is a strong argument for adopting this verification procedure. There were limits to the process of verification because it was thought inappropriate to share the model of staff responses with young people.

There are clearly limitations to this study. It involved a small number of participants and focused exclusively on residential care settings with young people. Older people and family settings in particular may generate different findings. Although there is no literature specifically on cutting in family settings, the literature on suicidal behaviour indicates that similar processes may occur within the family group (Hollis, 1987). The focus on young people meant that issues of care and protection were given high priority which may have resulted in more polarising processes than would be the case with adults. The work by Norton and Dolan (1995) with adults however suggests that the interpersonal processes highlighted in this study have relevance to other settings.

In terms of generalisability, young person participants were sampled from only two settings and the numbers were small. Although all participants gave unique accounts a set of consistent processes emerged. The extent to which these findings may be generalised needs further investigation.

The current study could have been improved by completing a first draft of the analysis at an earlier stage and discussing it with participants. This may have allowed greater opportunity to explore different avenues, in particular staff views of themselves as carers and what happens when this is challenged. The accounts could also have been analysed along different dimensions, such as examining how staff talk about staff, young people about themselves and about other young people. More detailed information regarding the young people's personal history and current life may have been useful but was excluded for ethical reasons which in retrospect seemed well founded. The young people may well have responded to requests for written materials and drawings about their experiences and this would be an interesting addition in future studies.

Tape recording of the interviews would have captured paralinguistic aspects and allowed others to analyse the data in more detail. The anticipated problem with this was that young people might want copies which would fail to protect confidentiality. The response of the young people to their anonymous transcript was often to show it immediately to peers and staff which supports the decision not to tape interviews.

The ethical issues about interviewing people who self-harm were complex. Most young people felt agitated by the interview saying it brought difficult issues to the fore and two

young people cut shortly after the interview. Staff reported cutting being common following therapy sessions which is consistent with this response to talking about distressing feelings. The young people all completed the interview, in spite of repeated offers for them to stop if they wanted and many reported that the experience of being asked about and communicating their views was very positive. The follow-up interviews were well received with participants corroborating the categories as accurate reflections of their experiences. Although only practical and philosophical arguments were made for adopting a qualitative methodology it appears that a very strong ethical argument could also be made.

5.4 IMPLICATIONS

Research

There are many potential avenues for future research, specifically in developing and evaluating the model in equivalent and contrasting settings. Empirical testing could be carried out by collecting detailed data about young people, staff and group processes around incidents. A study which combines participant's diary records with behavioural records, including events, interactions, thoughts and feelings would be valuable. To test the generalisability of the current findings, adults could be interviewed retrospectively regarding their experiences in care. Research could also investigate whether the findings apply only in situations where staff have a high level of investment in protecting the person.

Clinical experience suggests that young people may cut around particular staff members and that some young people may seek out particular staff members to clean them. This is very interesting in the light of the current study and should be explored more fully.

The wider issues around the process of contagion, the role of carer, gender roles and the use of cutting as a way of managing placements are also potential avenues for research which could contribute to extending the social aspects of the suggested model. Exploration of carers' personal histories, motivation and explanations of their behaviour would be valuable.

Clinical

The current study highlights the complexity of processes involved in the phenomenon of cutting operating at many levels. It appears that cutting serves multiple functions which relate to the young person's sense of themselves and experience of care. This implies that focusing on cutting in isolation would be counterproductive and the limited research literature supports this view. It appears that cutting or other antisocial behaviour can easily be seen as equivalent to an individual's personality which may lead to insufficient acknowledgment and development of healthy areas of functioning.

The interpersonal processes illustrated in the model suggest a variety of potential areas for intervention. Most striking was the extent of polarisation and pull towards straightforward explanations. This suggests that staff need to be vigilant in examining their feelings and motives and that staff groups be able to overtly examine conflicts and dynamics played out between staff members. As Norton and Dolan (1995) suggest the institution needs to

facilitate a wide range of genuine emotional feedback to allow the person to experience themselves more fully. This has clear relevance in the context of cutting and implies that group work may be particularly valuable.

With reference to the model, from a psychodynamic perspective the staff task may be seen to be to receive the feelings communicated by the young people and to process the conflicting messages and feelings without entering into the enacted cycle. That is, to avoid becoming unwittingly polarised while remaining emotionally engaged with the young person. In this way the young person may have the experience that the conflicting aspects of themselves are bearable and they may be able to begin to internalise this process which would reduce the need to cut. This is clearly a very complex task which requires staff to develop a high level of awareness of their own processes, to understand what of their feelings and responses are to do with them and what are communications from the young person.

This study also raises the importance of close consideration of the local interactions between people and how these may be contributing to maintaining perceptions and roles, and to wider social factors.

Finally the potency of acts such as cutting may lie in their ability to convey irreconcilable ideas in a way which matches the intensity and complexity of the person's experience. Verbal communication is often unequal to this task. Encouraging and developing creative activity is strongly implicated.

6.0 CONCLUSION

The phenomenon of self-cutting occurs in the context of overwhelming experiences which are unbearable for all concerned. The cutting appears to be concerned with managing life rather than about dying. A wide range of accounts for cutting were articulated which showed idiosyncrasy in terms of the meaning for the individual but also a high level of consistency in terms of perceived function. Cutting was predominantly seen as an intrapersonal process, a coping strategy for overwhelming experiences and as a self-punishment linked to beliefs about lack of self-worth. The cutting had a powerful and generally negative impact on others and two interpersonal cycles were identified. These were based on staff responses of intense engagement with an apparent aim of rescuing the young person and an alternative withdrawal response which followed from staff experiences of impotence.

There was a strong pull towards polarisation in views and perceptions which was illustrated in separating people who cut into two groups 'sad' and 'attention seeking' and in the contrasting responses to cutting. This appeared to result in rigidity rather than flexibility of thinking and frequent conflict of opinion. The findings were summarised in diagrammatic form and related to the current literature. The role of carer was identified as central and parallel processes occurred for staff and young people when they were in the carer role. The importance of local interactions in defining and maintaining perceptions and roles was discussed. It was suggested that the difficulty in integrating the conflicting and confusing experiences around cutting into a single account led to the extreme and rigid accounts of

the processes that may be occurring. Clinical and research implications from the research were outlined.

This study clearly indicates that those people closest to the phenomenon of cutting are able to articulate the processes that are occurring but this does not preclude them from being overtaken by them. A multi-dimensional perspective which includes intrapersonal, interpersonal and group processes as well as wider social issues appears to be central to increased understanding of this challenging area.

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Appendices

RESEARCH DIARY

Easter 96

First thoughts about project - somatisation and the way in which feelings are expressed through the body - negative stigma in Western Society. Collected literature but decided against topic.

Thought about therapeutic community issues, contacted various people. In particular the way anxiety is contained by staff. Lots of literature searches and discussion. Lots of ideas which didn't seem to be going anywhere.

June 96

Met with _____ and _____ to think about adolescent and staff experiences of attacks on self and others. The discussions helped clarify area of interest but it was somewhat disheartening that no one stood out as an obvious supervisor interested in this area.

July 96

Research proposal submitted.

August 96

Various correspondence. Met with _____ at _____ hospital and with Dr Coleman (Trust for the Study of Adolescence) and both were very interested in the research idea. Useful feedback and I started to feel excited about carrying out the research. John Coleman agreed to supervise me with back up from Lynne.

10 September 96

Met with John Coleman and tightened up research proposal, in particular focusing only on cutting rather than on aggressive outbursts as well. We thought it would be good to look at adolescent and staff pairs and the experiences of interventions to cutting. It was a relief to talk to someone from a residential care background who was interested in my ideas.

20 Sept 96

Contacted _____ and they were very pleased to hear from me and were interested in taking part.

27 Sept 96

Met Lynne. Exciting initially but ended up feeling very anxious. She seemed to be directing me towards a quantitative study or a survey 'back-up' project in case the interviews didn't work out. I don't know whose advice to follow and feel back to the beginning again.

30 Sept 96

First day of the research block. Discussed ethics approval and feedback from our proposals which had the effect of bringing on a headache and making me feel extremely anxious and wanting to get on. Who do I approach for ethics approval for a children's home? Also the potential for completely changing the project is again in the

air. Discussed that I had been getting opposite advice. She was not surprised and said the problem was primarily with the justification of the methodology rather than the project itself. She also raised how I was stuck in the middle of a split in Psychology in terms of quality vs. quantity. I feel quite clear that I would feel all right about doing a pure qualitative project or else a big questionnaire survey. Seems to me that a hotch potch would leave me feeling dissatisfied and doing neither properly. We wondered whether a powerful way forward in terms of justifying the approach I use would be to meet with a couple of adolescents and ask their opinion. i.e. if they were going to design the research how would they do it - grids, questionnaires, stories, interviews? I became aware of how I had assumed that they would prefer to talk in depth and may be assuming wrong. Philosophy of qualitative research is to put yourself alongside participants. This would be a creative way of approaching the methodology problem.

1 Oct 96

A rush of phonecalls about Ethics Committees inspired by yesterdays teaching. helpful, phone back tomorrow. and Social services didn't know what I was talking about. I explained and drafted a letter but feel a bit reluctant about sending it, anxious that social services will stop me doing anything and maybe they're not the ones to decide anyway.

3 Oct 96

Lots of emphasis on qualitative approaches in the teaching, left me feeling interested and committed to a qualitative approach but also anxious that my project doesn't fit the bill. How much is to do with my lack of confidence and clarity? Every time the dissertation comes up I feel extreme emotions. Sometimes I wish I was doing something less important to me that would fit in with the majority quantitative culture.

8 Oct 96

Just finished new version of my proposal to send to John and Still getting opposing advice. I was encouraged when I spoke to John a few days ago that I should stick to my guns but as I uncover more and more literature I'm feeling less certain. Lots of odd jobs done- collecting survivors literature from the various organisations to see what is being done. Psychiatrist at was very encouraging about the usefulness of the research in particular as it related to management. I was very struck by her use of language, borderline, behavioural methods, contagion etc as these are so contrasting with I'll have to be a Chameleon and change my language to suit the audience. This is the whole point about qualitative research! I have such stuck phases when I have to write anything. Worried about whether to add the PBI in. Am I just trying to make people feel happy? Sometimes I just want everything to be sorted and am getting the feeling that qualitative research is going to be a bit like this, questions, questions and no neat formula.

11 Oct 1996

I was struck in our presentations to the group today about how much more of a grilling and I got. "Justify your methodology, why this why not that?" No one else had to argue their way into using a questionnaire. I'm beginning to feel burdened down by being in this argument and realise that I must read more and know what I'm doing and why. Otherwise I will get squashed. Very encouraged by interest in being in the qualitative group, "follow your heart".

14 Oct 96

Lots of philosophy. I've written to _____ and phoned 6 times. The director is never in and am beginning to feel that it's a waste of time. Something that gets to me about the researcher role is how you can work so hard to contact people and be interested in what they're doing and yet they don't even bother to respond. More reading in the recent edition of *Changes*. Beginning to understand a bit more what qualitative research is, still don't know if it's applicable to my study. I'm thinking more also about why it is I want to do this study. It is definitely something to do with returning to a time when I felt more competent and useful, i.e. working in residential settings. Like going home. But am I really interested in what adolescents say about their cutting? It seems more to do with provoking the status quo, opening up different lines of communication. I'm as interested in the emotional reactions of staff towards cutting and their rationale for responding punitively. We all have so many assumptions and ideas about how people might respond. This often comes from the literature but in this case I feel more influenced by _____.

28 Oct 96

Just completed submission for _____ Ethics Committee. It seems to have taken ages and I hope they just say yes. I rather doubt my ability to convince them about my methodology. Met with _____ last week for two hours and went through the proposal. She was very supportive and I left feeling that the research really is going to happen. I also received a letter from _____ with someone to contact about participating. Still getting little feedback about the research and feel as if I'm making it up. This is so contrary to what I thought I was looking for initially i.e. a quantitative straight forward project with knit picking and regular supervision. I don't really have a sense of being supervised. Must I discover a sense of my own competence about research?

I'm nervous about submitting my stuff to the Salomons ethics committee in case they reject it or ask for more justification of the methodology. I'm just putting it off and will have to do this next before I can do much more. My ethics committee application to _____ is being considered tomorrow so I should hear from them soon.

6 Nov

Discussed the first staff interview yesterday at _____. It was quite nerve wracking. She was very eager to talk and the questions turned out to be good prompts. Overall the interview was more emotionally intense and moving than I had anticipated and evoked strong memories of my time at _____. It was difficult to feel safe even doing the interview since 2 or 3 of the adolescents kept coming in. I turned my transcript over but was anxious that they might grab it. They really are so provocative, it made me feel quite nauseous, all that anxiety came right back. I felt so glad that I could walk away and didn't have to manage their behaviour. I suppose it related to the strength of feeling that came through the interview, and painful feeling of impotence in the face of unbearable pain. I was left wondering what the interviews with the adolescents will be like, whether they would be capable of sitting and talking or whether they'd abuse me. It's very different if you don't know them. One was very rude to me and I wasn't sure how to respond.

There was a lot of detail in the interview which felt very important and relevant. Confirmed my idea that this would be an important area to pursue and I'm feeling more optimistic that it will actually happen. We discussed the interviews with young people and lots of hurdles need to be got over, parental consent etc. I got a very strong feeling that they will help me. I think partly I sensed there was something I could give to them in terms of a chance to gain a greater understanding of what cutting is all about.

Letter to to thank her. I'm realising how important it is to have people supporting from the actual units and am working hard to help them. I can imagine that embarking on this research without good link people would be a nightmare-like it's turning out to be with , with absolutely no response from them despite 15 phone calls. When will I give up? Bumped into at the . the other day and he is very keen to meet as well. This is all very encouraging. I like it when people treat you as if you've got something to offer.

12 Nov 96

Met yesterday with young woman at to discuss the young people's interview. I was nervous...would she like me? had organised it and contacted Social Services as a courtesy to let them know I would be meeting with I feel very supported by . I had wondered how she had found the interview but she is obviously very committed to seeing this project through and getting involved.

Meeting was helpful and also increased my confidence that I can relate to young people. She kept changing the subject and telling me about other parts of her life which made me realise how important it's going to be to have a kind of warm up/ rapport building bit at the beginning of the session. She gave helpful feedback about the questions, in particular about the language used and about asking young people what they think about other people who cut. She could have talked about this for a long time but I was trying to keep the boundaries clear, i.e. our meeting was to look at the interview rather than do it. She was keen to participate.

There was quite a lot of excitement generated by my meeting with and she called a member of staff up and started grilling her about her feelings about cutting. Another young person then joined in. I was left wondering what sort of impact this focus is going to have on the young people's behaviour. Could it promote an outburst of cutting or something else? It's difficult to answer this Q but it became clear that it will difficult to miss some of the young people out - so what then happens if someone is thought to be unsuitable?

15 Nov 96

Heard back from the Ethics Committee. I was initially disappointed because the letter was long and detailed about the areas I had to look at again and a meeting was suggested that I attend. So I haven't got approval yet and it looks as though are taking a very different approach to . Having looked at the letter carefully I started to feel pleased that I was being taken seriously, all the recommendations were valid.

I phoned [redacted] and [redacted] again today as I'm feeling quite anxious that they didn't respond to the stuff I sent them. I'm irrationally worried that they think I'm being presumptuous and will not allow me to continue. This is what this whole process is like it seems, particularly because you rely so much on other people's goodwill and reliability. I will feel really happy when I actually have the transcripts and then can just get on with the analysis and write-up.

10 Dec

I got increasingly paranoid that [redacted] were plotting against me and was about to cancel my planned interview on Sun evening when I hadn't heard from them. Then the phone rang and they said sorry, all was chaos, everything is on tomorrow. I was partly relieved and partly disappointed as it meant more work and anxiety. Anyway, yesterday I interviewed a young woman who cuts as a pilot and a member of staff. Being around those kids is nerve wracking in itself but doing the interview turned out to be pretty stressful. Apart from the material being painful, she became quite agitated in the middle and brought out a pile of shavers, then demonstrated how to get a blade out. I was panicking. I thought after all my ethical hurdles, here I was on my first interview and she was going to cut in the interview. It was like being at [redacted] again. These kids really can get your adrenaline levels up within seconds. It resolved OK and we had a long wind down period but I don't think the timing was good for her and that reflected really the lack of thought from the unit, since I couldn't have known about these events that were happening in her life. Also Christmas is stressful so it's probably good that I'm starting in the New Year.

This gave a taster of how emotionally draining this process is going to be but equally also some insight into the organisational problems, particularly as regards consent.

19 Dec

Ethics meeting at [redacted]. There was a panel of 5 including a solicitor and we met for what felt like a gruelling 2 hours. Everyone was friendly but the questions were hard and there were no answers that all would agree to. The main issue was re confidentiality. Should the participants be allowed strict confidentiality in a treatment setting? How would I know what the staff already knew about in the event of potential disclosures of information? Exactly what info would I pass on and what wouldn't I? There was a clear split between the consultant and solicitor. Consultant seemed to think it would all be fine, I could chat with the staff later and the kids would not have big issues re me being in the role of the clinical team. i.e. info kept confidential within the team, I can be trusted to pass on whatever seems relevant. I wanted a clearer position, and a clear understanding about the sorts of info it would be agreed that I would pass on so I could tell the participants at the beginning. The solicitor was at the other end advocating strict confidentiality i.e. if someone disclosed previous sexual abuse this would not be passed on, the only things to be passed on relating to current or immediate potential harm to self or others. We discussed this till exhaustion and still didn't seem to be at a resolution. General wording agreed on was 'I will keep what you say to me private, unless I think it is harmful or illegal to do so'.

The interface between clinical responsibility re confidentiality and as a researcher is very interesting. Exhausted. Please let this go through quickly, it has taken 5 months

to get to this point. Why did I choose something with so many ethical problems? The other key issue was about the consent forms and how there needed to be 3. For young person, Clinical Team, parent/SS. had different ideas, there should be 4. One overall from directors, young person, parent/SS and senior staff member on the day of the interview. For each of these groups there has to be an info sheet so I am swimming in paper.

21 Dec

Response from ... good, we like it but now it has to go to a few other people to approve and they will be in contact.

Holiday

Not the most relaxing Christmas but wonderful to stop for a bit. I was so stressed with all the juggling in my head, constant tension headache. Returned not very eager, wanting to have finished yesterday.

13 Jan

Contacted at , to try and set up more interviews. It is all so complicated. Courtesy calls to be made to SS, doesn't make sense if I do it, key worker won't know who I am etc. and I agreed that she would take it to the staff meeting this week to distribute info and let them know the procedure, which is still changing. Anyway, I arranged 2 interviews then heard that the young women would be at Centre Parks! So my plan of trying to interview more than one young woman at once is not working but I will go each week and try to get 1. It is better to try to keep going I think as may suddenly get back to me.

I started writing notes from the cutting literature. This is going to be a long task but it felt constructive getting started. Bit worried about how much lit there actually is now that I have done my searching, hoping that my project is going to be of some use. Wrote out a nice Timetable for progress and started filing and writing lists of the refs. I have got. These jobs, and doing photocopying, all make me feel more in control. I'm determined to try and avoid the level of stress before Christmas.

29 Jan 97

Did two interviews at on Monday. As usual it was quite a palaver. The first girl was in the bath and then refused to take part until she had cigarettes so we walked to the garage. The interview was then very short as she only gave monosyllabic answers. It was very striking how limited she was in expressing herself and she even struggled to understand the Q's. Quite agitated throughout. I was struck with how disturbed she was, walking along the street spitting and shouting at the trucks and unable to sit and talk without constant distraction. I don't think it was just the interview. Afterwards she asked for copies of the research and gave me a hug, thanking me for interviewing her. It was a strange feeling as I had thought it seemed like quite a waste of time whereas she obviously felt listened to.

My second interview was with a member of staff who arrived an hour late. It seems that I will have to get used to hanging around without getting too frustrated. The interview was good though not completed as we ran out of time. She found it difficult to say much about her own feelings towards the girls even with prompts and tended to

focus on the girls feelings. Not clear how much a part of the culture this is. She said she found the interview much harder than she had expected as she really had to think. Said she was glad she'd done it and that she'd finish it another time.

I've just typed up both transcripts. I'm worried about getting enough young women. have proposed that I spend some time hanging around the unit getting to know people first, with all my spare time! So, I went to the school room to introduce myself and they were so horrible, very hostile (2 young women). It was so familiar and made me feel sick. I knew I would be able to engage them with some effort but I couldn't face it and found myself saying 'well it's up to you, I'll come back another time'.

I contacted today though they haven't returned my call yet. Still haven't heard from them re whether I can proceed. It's just one woman who needs to write and yet I'm totally dependent on her. I have to decide a date after which I'll give up and start to pursue elsewhere. I'm realising that finding older adolescents would be very much easier.

2 and 3 Feb

Did two staff interviews and met 2 young women to discuss the research with them, see whether they are interested so I can pursue SW consent. Someone drove into the back of my car on the way so it was a god job things went OK, very stiff neck. The unit is still chaos and the staff member booked for 9.30 became free at 11.30 and then had to do a Sainsbury's shop so I had to interview her in a coffee shop.

The staff interviews were interesting, both talked much more about negative feelings and the ways in which staff can get unhelpfully drawn in. I agree with this and was feeling uncomfortable that the other staff I'd talked to had been so loving and caring. Another feature was that they both made a qualitative distinction between superficial cutting where it was mostly to do with the impact on others, 'projecting conflict into those around them', 'attention seeking', and other cutting which feels serious, disturbing and something much more important. The therapeutic community interview was definitely the most insightful in my view and I suppose my alliances are becoming obvious.

Met the two young women again who had been hostile to me. They were much easier to engage and genuinely seemed interested. They want to be interviewed together and I've put everything in motion to get SW consent. The 3rd girl I'm approaching is a very serious self-harmer and two senior staff told me to arrange the interview when there was a strong staff member on or she would cause havoc after I left. They said she 'goes off with any excuse' and because people are so anxious about her, frightened by the degree of harm, they aren't firm and calm. So, I'm looking forward to it!

5 Feb 97

Just typed up the 2 staff transcripts, I've got back ache but am pleased. I've now done over a quarter. Still haven't heard from

27 Feb 97

Got the all clear from and did two staff interviews (the girl I was going to see had been really ill over the weekend).

 has a really different atmosphere, much more organised and medicalised. The 2 staff met me in interview room and seemed anxious to please. The interviews were good and both took longer than an hour. The different ways of thinking in a hospital setting were striking, one to one 'specialing', clinic room where cleaning and stitching of wounds is carried out etc.

Met with Lynne today to discuss progress to date. It was really good talking through the ethical issue of interviewing the young women. I've been wondering whether interviewing them is damaging in some way and realised that I find the apparent lack of care after I've gone upsetting. So the ethical issue is whether the young person's right to express their views, and their motivation to do this, is outweighed by the negative impact of thinking about difficult issues and leaving them in a less than ideal context. I think the whole issue will remain difficult to manage. The extensive ethical procedures that are in place don't prevent these personal ethical issues arising and there is a question as to whether any safeguards would actually help.

Attending a conference on self-harm on Friday and hoping this will provide inspiration and help me to feel that I do have a good grasp of the field.

10 March 1997

Just did two interviews at . They were both quite difficult. Both were well spoken but difficult to communicate with, speaking quietly and managing to elicit a lot of anxiety in me. I ended up wondering whether I was doing something unhelpful with them. The second girl in particular was very stroppy, not answering questions and being hostile. Very early into the interview I commented that she didn't look like she wanted to be here and it was fine if she wasn't in the mood but she shrugged and carried on. A strong ambivalence from both of them, they volunteered and I gave them many cues so that they could leave. I feel very responsible for their well being and guilty I suppose, because I need participants, that I want them to get something out of it. I suppose I had fantasies of talking with young people where I had a good relationship and then went into the meetings with these girls who made no eye contact. I'm really no one to them and that is painful.

Conference. The self-harm conference on Friday was disappointing. I was hoping that I would feel stimulated and learn a lot whereas actually I'm not sure I learnt anything except that my research is definitely worth doing. People really do not know much. I missed the bunch, we should have been there. The presentation lacked substance, the one was better than I had thought. Basically the very key relationship between the person who self-harms and the staff member was missing, as was any reference to theory. People alluded to powerful counter transference but none of it was put together. The questions on people's lips were, well what do you do?, does it work? what is better, ignoring them or being very intimate? All together I feel empty from the experience.

27 March 1997

Have just finished typing 5 transcripts, have finished more or less at . The last 4 interviews I did in one day and have been feeling traumatised since, and I became ill. I think it is all too much. The role of a researcher has meant that I have been listening really closely to what the kids have said and it has been intense, picking up on the overwhelming feelings of misery and despair. Then moving to talk to staff who say it doesn't bother me has felt unbearable. I am struggling with having this intense experience with the kids and then leaving them in a very inadequate way. This links to the closure of I think and our effective abandonment of those kids. I thought I was doing this research to somehow make up or say thanks to the kids or something, but of course what is happening is I'm feeling awful about misusing or abandoning these kids. The medical environment is so different from what I'm used to.

Met with Lynne to talk through the interviews, it was hard as I was feeling rough and more interested in going to bed. Basically I'm feeling overwhelmed and though I've achieved a lot I want to stop and just go to sleep. I wish I wasn't putting so much stress on myself, maybe this is my own form of self-harm, I certainly feel wretched. Now I'm stopping for Easter, my plans for writing some of the introduction abandoned. A lot of abandonment going on around here.

25 April 1997

I'm trying to write the introduction, or at least to make a first stab at it (apt use of metaphor). Any diversion is good enough, eating, playing the piano, writing this diary etc. There is so much to read it's just like doing another essay. But I think for me this is the hardest section and my plan is to get enough of it done so that I can concentrate on the analysis. I'm thinking more about body alienation and wondering whether I asked enough about it.

I saw two of the girls I'd interviewed to go over their transcripts. They were quite manic as usual but seemed genuinely moved by the level of detail they'd given, seeing it in print seemed quite significant. They didn't want to change anything and it was striking that the girl who wanted to keep her transcript was the less serious cutter, the other girl seemed more uncomfortable and wanted me to keep it. They were both more friendly and pleased that I had come back. I did my last interview as well. I had been dreading it and having all sorts of fantasises about why she might not be able to do it.

The interview felt awful. I think my role as a kind of observer to their distress has a big impact on me. I feel very impotent and guilty/responsible for the feeling of poor care that is conveyed. Maybe it's partly to do with being able to really listen to what they are saying in a way that is just not possible when you are working with them. I found it almost unbearable listening to this girl, and this is exactly her experience, that she is a page in people's diary and people don't want to hear what she really feels. Well I can understand that response in staff. Being with her was like being tortured. I wonder what all this has got to do with my motivation. It was very predictable that this interviewing process would be very painful. Maybe this explains too why so little research has been done directly with adolescents in this distressed state. The people who were further removed from the experience of cutting, or those who did it superficially, were much easier to interview and seemed to feel quite valued in talking

about it. The two girls who were in a bad state were full of feelings of worthlessness and the real despair of their lives.

I talked briefly about my research with a child psychotherapist the other day and quickly felt quite shocked with how powerful my feelings are about this process. I realised that I have been blocking off some of this just to get to the end of the interviews. The disturbing effect of the behaviour on the people around is so clear and this is part of what has been happening to me. I feel like I can see abusive care practice all around and yet I know that both places are not bad and also can understand the necessity of defending oneself from being overwhelmed and disturbed by these kids.

General Election Victory!

2 May 1997

Met with Lynne to discuss progress. I was feeling so happy and excited about the election, also exhausted from having stayed up for the night. For the first time in ages I found talking about my research exciting and as though I could do something quite creative and original with it, rather than just feeling anxious about whether I was fitting in with what was the 'right thing to do'. I realised that the whole tension about methodology links intimately to the subject and also to my own development as a researcher.

The subject of cutting is about something unthinkable and quite unbearable. The response to this state of affairs in terms of research and also treatment has generally been to try and reduce or simplify the issue so that it becomes more manageable, i.e. as a defence to becoming overwhelmed and filled with uncomfortable feelings. Staff do this, so do researchers and academics. Even things like concentrating on sexual abuse as a causal factor end up minimising the effects of the whole family experience and all the dynamics that may have been influencing the persons development. And this way of looking for linear explanations or even neat and all encompassing explanations comes from a positivist tradition. So what I was thinking was that cutting so provokes anxiety in those in contact with it that it is even harder to respond in an open way and to let go of some of the reductionist assumptions that help us cope with overload or ambivalence. I thought this made a lot of sense in terms of my project because the area which is really missing is the complex overlap and interrelatedness between the internal world, external world and all that moves between.

Mahe 1997

I read Mike's paper called the 'Compound I' for his IGA training (see reference list) and felt quite inspired by the ideas he was presenting. It made me realise how profoundly I've been influenced by working in the therapeutic community tradition where the individual is never really considered in isolation. The ideas in the paper are firstly about the historical development of thinking about the self or individual, how the forces that impinged and influenced the self were previously located in external forces such as God and through the development of psychology and psychoanalysis these forces became located inside the person. Mike used the analogy of the compound eye in insects to illustrate what he thought was important in group treatment. i.e. that intrapsychic understandings and changes are not sufficient. The impact of the inner

and outer world on each other is central and the compound 'eye' or 'I' relates to the way in which different perspectives of the person or context combine to produce a picture.

I think a lot of what has been missing in the cutting research is the interface between the internal and external and the way in which everyone defends against this, perhaps to avoid being impacted on or contaminated by each other. This idea of extending understanding or multiplying potential influences also relates to the philosophical position attached to qualitative methodology and in my experience is much more connected to the experience of being around people who cut. i.e. it is extremely complex with a host of interrelated and often contradictory experiences. I was thinking through talking to Lynne that one way of introducing this study would be to bring in the philosophical argument very early on as I think using a quantitative or reductionist approach to the area I'm looking at would be a defence against the material. This sounds complicated. There is a real risk of me sinking in the complexity so I have just written a detailed timetable of what I'm going to do to defend against that!

7 May 97

The weekend was a real struggle. My anxiety had been sufficiently raised by seeing peers but I was feeling overwhelmed and quite unable to concentrate, so I wrote a plan. It worked, I feel much better. The last few days I have been starting on the analysis, going through the transcripts and writing comments in the left hand column and key words/points in the right margin. This is exhausting work but I have done most of them. The difficulty is that it is all complex and interlinked so that pulling out discrete themes may not be possible. Today I began making a first map of where I was so far. I found myself gravitating towards the staff responses, whether this is because I can relate more easily to this or am avoiding something I don't know. Anyway, I think that a potential approach will be to look at the staff picture and young person picture separately and try to bring them together at the end. The advantage of looking at the more interpersonal aspects is that a lot of the dynamics are quite stark and this may be more difficult to see from an intrapsychic point of view.

Much seems to be revolving around what it is to be a carer and how someone harming themselves is an attack on this relationship to the very core. It seems that 'not being able to stop them' provokes a kind of crisis in the staff and they respond in different directions, I would speculate in familiar ways to them, eg the people who block it all off, those who come to the rescue etc. The parallels between the young people and staff are also striking and it may be that the way that they relate at the end of the day is a kind of dual process going on with various pivot points.

I found myself drawing little diagrams today showing different poles, internal to external, concern to anger and thinking about people being on the continuum of these poles but also oscillating between various points. It is all about unbearable feelings and what to do with them. So many contradictory feelings and desires are expressed, all around the theme of caring, that I was thinking that maybe 'containment' in this context relates to the ability to hold onto the conflicting feelings rather than plumping for one. I feel impatient to get the bits into some sort of order as it is quite intense

letting all the fragments fly around. I've found that I can only work properly for 15 minutes at a time and am using an ever increasing number of distractions.

9 May 97- 17 May

Met with John which was very helpful. I realised through discussion that I need to go back to the data and start sorting it in a systematic way. I find it hard stopping myself from going off on tangents. John asked a lot about the emotional impact of the interviewing on me and acknowledged how much I'm having to manage. It felt strange that in some ways as my supervisor he might have been able to help me with that but due to the infrequency of our meetings and also perhaps the way it was set up, i.e. that I asked him to be my supervisor on the basis that I would be very independent so I've been cautious in asking too much, that hasn't been the case. As in all areas of my life at the moment, sometimes it is easier to block off everything than just noticing that I could do with more emotional support. Lynne has been great but I think the fragmentation has meant that there really is no one person who I rely on.

I sorted the data into discrete categories which took hours, numbering each paragraph and then cutting them out and sorting into piles. But at least it feels like I'm back on track. I did some more reading re methodology which I find either very supportive or throws me into another whirl of confusion. The Smith article that Rudi gave me has been the most helpful as it describes the approach he takes, interpretative phenomenological, and he follows this through. This makes much more sense to me than sticking rigidly to grounded theory because this is not really what I am doing. After all I have so many of my own ideas already and also it feels like the process is quite interpretative as I have to speculate as to what hasn't been said etc.

17 May

I met Rudi yesterday to talk more about methodology. We ended up talking a lot about discourse analysis and constructionism and I felt quite overwhelmed. I oscillate so much between wanting to really understand what I am doing and to try and find the best approach and just wanting someone to tell me what to do and what it is. What I'm realising is that I am doing the analysis. The moving backwards and forwards between description of the data and more abstract conceptualisation of it is the analysis. So now instead of feeling like I'm in a real mess I think this is it. It's amazing how the literature describes all these fancy terms which somehow miss what the experience of doing it is like.

This morning I decided to try and clear up in my mind what the differences were between grounded theory, narrative approaches and discourse analysis. Also where interpretative phenomenology and symbolic interactionism fit in! I haven't solved it but I do feel a bit clearer. With all the quantitative/qualitative debate I hadn't really appreciated the huge debates going on within qualitative research. Someone in the Richardson book talked about the 'qualitative dilemma' which revolved around whether you take a position that there is something out there to be described and grounded theory for example will help you do that, or whether you go along the social constructionist line and believe that experiences etc are constructed depending on a whole host of factors including the research situation and bias etc of the researcher. And the latter moves into the discourse stuff. I think what I have been having trouble with is that I want to describe and present the experiences of staff and young people

with respect to cutting behaviour as they see it, from their perspective. So this would be a phenomenological approach. But also I think the context surrounding all of this in terms of power positions, how people account for their experience etc all comes from a more constructionist sort of position.

I am not going to use discourse analysis as this is more about the interplay in dialogue and the way that language is used and my data aren't detailed enough and also this isn't really what I'm interested in. So it seems that grounded theory type methods are what I'm using. But there will be quite a lot of moving away from the data to a more abstract level of explanation which invariably draws on my position. I think the symbolic interactionism bit is referring to the way in which experience gets its meaning through the continually occurring process of interaction and relationship with other people. This in my mind has some similarity to object relations ideas about the development of the sense of self. There is so much to wade through I feel I'm getting more confused as I write this.

I think what I am doing is using a modified grounded theory approach. I am not starting from the position of having no ideas or explanations about the phenomena so I am not a 'blank' waiting for categories to jump out at me from the data. Rather I am using a recursive process of moving in and away from the data, all the time drawing on my ideas and perspectives, so this will have to be presented somehow in the paper. I am using some interpretation of the data to understand and speculate about the interconnections between things and what might underlie them. And this is where I think I will have to move more constructionist because what I think is coming out is the way in which the construction or underlying discourse around certain areas such as being a carer as a job has a massive impact on the way people are feeling and explaining what is going on.

It is probable that this meta sort of level will come out more in the final theoretical and discussion part of the project and that the main body of analysis will be a systematic structuring of the data combining grounded theory and my own interpretation. I am still not clear where narrative approaches come in and I read an article from Rudi on accounts and how people go about creating explanations which sounds very related to what I'm doing. It's very interesting how the explanations are either on an intrapsychic or interpersonal level, i.e. basically psychological, and how no one mentions biology or sociology. I actually hadn't thought much about broader sociological issues and stuff to do with power and gender although one of the staff had mentioned it in passing. I suppose that shows my bias towards looking for psychological explanations.

Today I read an article by Rudi about sexual relationships and discourse and there was a lot about gender and power and it got me thinking about the power imbalance inherent in being a child in care and how cutting oneself shifts the balance of power by putting staff into a more helpless position. This is consistent with the findings that cutting occurs less where people are given more freedom and responsibility. There's so much to think about. I had no idea qualitative research was so fragmented but I feel more optimistic that I can find a way of explaining and justifying the particular approach that I'm taking. It won't be mainstream but I hope it'll be coherent enough. Anyway, it seems to me that there is actually a lot of overlap between the various

positions, using funny language is just there to get you in a mess. Where will this all end?

I wish we had had a teaching session overviewing the various approaches because it is anxiety provoking when people keep adding , ‘well what about a narrative or symbolic interactionist approach?’ I met with [redacted] to discuss his project and it seems he is equally at sea re not feeling his project fits neatly within the prescribed grounded theory model. Also I saw the methodology sections of a couple of [redacted] trainees the other day and both of them drew their approach from grounded theory and discourse analysis. I must admit I wondered if that was just taking a bit of everything in the face of confusion but it did make me feel freer. I think it will take a whole lifetime to understand what this stuff really means as it is all so intimately entwined with philosophy. I’m glad I did the philosophy of science option as an undergraduate but wish I could remember a bit more of it.

1 June

A lot has been happening. I have been through the initial stages of the analysis, producing a summary of categories which I am taking to [redacted] today to discuss with staff and young people which feels quite exciting. It has been difficult to produce something that represents fairly what people were saying. Anyway I feel that things are moving along and got some positive feedback from Rudi re my 1st draft which was encouraging. I’m still confused about how my analysis can be described but have written a draft methodology section combining constant comparison methods from grounded theory with a more interpretative approach and am going to try and weave in my ideas and feelings into the write up in some way. Time is running out and I got into a real panic last week about all the other commitments in my life that are taking up time. It meant that I worked frantically on Wed and actually achieved a lot. So I’m hoping that a weekly blast and carrying on at my normal pace will be sufficient. I’m feeling more excited about the research again having got something more concrete and particularly having received feedback.

4 June

I finished a first draft of the introduction today and met with Lynne re the method and first analysis drafts. I was excited about meeting because I’m finding the feedback gives me some excitement and enthusiasm to keep going.

We had a very good meeting, discussing where I’d got to and how it might develop and be structured. We thought that a section called ‘guiding propositions’ would best represent what I did prior to data collection. In a way this is like a 1st stage of analysis. This will include why I’m interested in the area, bringing together my experience and the literature. What the aims are and a series of propositions which guided the research. I could also include preliminary discussions with staff and kids here. This would lead to a Design section, just outlining the 2 groups, adolescent and staff and how I was exploring subjective experiences within and between them . Also mentioning the different settings which were included to provide depth and the widest range of possible explanations so that it would be possible to draw out the more generalisable features.

This would lead to methodology which I need to reduce a bit. Then the analysis section would be presented (2nd order analysis) which includes the verbatim extracts and derived themes. Then a section on the subjective experience of doing the interviews where I could highlight how it was for me, traumatic and becoming polarised. The next section would be drawing together the literature and themes to a more theoretical level (3rd order analysis) where I could link into some more abstract themes like 'flexibility or rigidity', or polarisation of the roles people are drawn into. This section will need to link all together and end with a model and finally the implications of all this and critical review.

I had lots of ideas as we were talking, mainly about how to draw on the multi-dimensional levels of understanding. Too many ideas but it was constructive and giving a structure to the scheme of things feels like a relief. There's still loads to do but I guess when you get to starting on a discussion it feels like the end is somewhere in sight. So now I have to get a draft of the remaining sections to Lynne by the Friday after next! (no I got that wrong, it's for next Friday and with my brother's wedding in between - oh no).

20 June

I've completed the follow up discussions with participants looking at the summaries. It was very moving seeing how engaged they got and how they obviously felt they were part of the process. I haven't experienced this with previous projects. Staff discussed the model and got quite excited, in particular about the rescue versus withdraw part which they thought was accurate. All said that they just had to get used to working with cutting and that they didn't think about it. It seemed that talking about it through the interviewing process had revitalised some of their curiosity.

25 June

I've been really struggling to write the discussion. I thought it would be easy but as I have gone towards a model type discussion it has been incredibly hard work. Lynne and Rudi are keeping me going. Submission in a couple of weeks!

6 July

I'm now doing the final alterations and getting all the appendices etc together. It is hard to believe that it is all nearly over. What I have been realising is how the whole process of doing the project has been like a continual reflexive process with new ideas and insights occurring all the time. Obviously there is a point when you just have to stop and I have almost reached it but I'm sure the whole thing will continue to develop. Taking a qualitative approach has been completely different from my previous research experience, more challenging in lots of ways but also more rewarding, I think for all concerned. After submitting I'm attending staff meetings at both Units to discuss the project with staff which I'm looking forward to. Time to sign off.

PRIVATE & CONFIDENTIAL

19th February 1997

Ms Vivien Norris

Dear Vivien,

Research Proposal: Adolescent and Staff Experience of Self-Cutting Behaviour in Residential Settings. A Qualitative Study.

I am pleased to inform you that both this Hospital's Ethics (Research) Committee and our General Manager, , have given their full support to your research proposal, as attached to your letter to me dated 21st December 1996.

The Committee's Chairman, , has asked me to apologise for the delay in coming back to you, and to tell you that the Committee would be interested to see a copy of your paper once you have completed your research. If you have any queries or problems during the course of the research project, you are welcome to liaise further with the Committee.

Yours sincerely,

Ethics (Research) Committee Secretary

24 October 1996

Ms V Norris

Dear Viv

Thank you for your letter. We keeping missing each other on the 'phone, so I am writing to let you know that and are particularly interested in meeting with you to discuss your research project and to offer any help they can.

 is happy for you to telephone her at home on if you are unable to contact her at and she will liaise with if you are unable to reach her by 'phone at .

Together, hopefully, you will manage to arrange to meet.

Very best wishes

PERMISSION AND CONSENT TO CONDUCT RESEARCH

Title of Project Self-cutting in young people who live in residential settings.

Researcher: Vivien Norris, Psychologist in Clinical Training

Outline explanation

Self-cutting is a confusing area and people have different opinions about why someone might cut themselves and what can be done to help. When young people cut themselves in a residential setting, the adults/staff have to decide how best to respond. This research is trying to increase the understanding about how young people feel about their cutting and to get a clearer idea about how adults might help.

What would be expected of people who decide to take part?

All information for this research will be obtained from a face-to-face interview with the researcher which will last not longer than an hour and a half. For the young women, participation will be initially discussed with the key worker. If the young woman expresses an interest in participating, consent will then be sought from the appropriate parent/guardian/social worker. For young women aged 16 years or under, this will be written consent. On the day of the interview written consent will be sought from one of a named group of senior staff members on duty and the young woman. The interview will not take place unless these requirements are met.

The focus of the interview is about the person's experience of self-cutting or being around people who self-cut; why they think people cut themselves and what they think a helpful response would be. There will be a debriefing following the interview. I will be interviewing some members of staff, some young people who self-cut and some young people who do not self-cut, but have friends who do.

All personal information given in the interview will be kept confidential, unless it is harmful or illegal to do so. Any information passed on will be discussed initially with the participant. Information that could lead to identification of participants will not be included in the write-up of this research. Anyone who agrees to participate can withdraw from the study at any stage without necessarily giving a reason. The well-being of the young person will be of central concern throughout.

I (Director of _____) _____ Date 3/2/97

hereby give my permission for this ongoing piece of research to take place at

. I give overall consent for the young people to participate on the understanding that the further consents named above are also given.

<u>Age</u>	<u>Family Information</u>	<u>History of Self-harm</u>
17	No contact with family. In care for several years. Sexual abuse.	Cutting for 5 years. Serious, regularly needs stitches. Previous overdose and hospitalisation.
16	Some contact with family, no further information given.	Cutting for 4 years, approx. once a week, not serious. Previous overdose.
15	Staff member seen as family.	Cutting for 2 years, occasionally serious. Previous overdose.
14	Some contact with family. Many years in care.	Cutting 1 1/2 years, usually not serious.
16	No information	Cutting for 2 years, very serious, multiple methods for self-injury and previous hospitalisation.
<hr/>		
18	Contact with mother and brother.	Cutting for 1 year. Previous suicide attempt led to hospitalisation.
16	No family	Cutting for 1 1/2 years, serious requiring stitches.
17	Some contact with family	Cutting for 3 years. Very serious self-harm. Previous suicide attempt.
18	Some contact with family	Cutting for 2 months, not serious. Admitted to unit due to self-harm.
18	Contact with a brother	Cutting for 3 months, no further details.

SEMI-STRUCTURED INTERVIEW SCHEDULE

Participant No. _____

TO BE READ OUT TO EVERY PARTICIPANT BEFORE THE INTERVIEW BEGINS:

- Thank you for volunteering to take part in this research. I hope that you will benefit from the chance to talk about your personal experience of self-cutting/working with people who self-cut.
- I hope that this research will influence the training of staff working with young people.
- I would like you to read the consent form that you were given before we met and for you to ask me any questions you may have about this research before I ask you formally to give your consent to the interview.
- I would like you to know that you can stop the interview if you want to and you do not have to give a reason. If you do not want to answer a question just say so and we will move on to the next one.
- I will keep what you say to me private unless I think it is harmful or illegal to do so. I will not pass any information on without talking to you first. No names will appear in the write-up.
- I will provide a summary of the results which you will be able to request.

(ALLOW TIME FOR THEM TO READ CONSENT FORM)

- Do you have any questions? (record)

(SIGN CONSENT FORM)

Record interview date: _____

Record time interview began: _____

YOUNG PERSON INTERVIEW

Section 1: BACKGROUND DETAILS

How old are you?

(The next two questions are personal and you do not have to answer them if you don't want to).

Could you tell me who you regard to be in your immediate family?

Could you describe what you feel is important of your family history and how you came to be staying on this Unit?

What do you mean by 'cutting'? (Definition)

Section 2: EXPERIENCE OF CUTTING

How long have you been cutting yourself?

When did you start cutting and why?

How often, when and where does it usually happen?

What do you cut yourself with and where on your body?

What is the experience of cutting like?

Section 3: EXPLANATIONS OF CUTTING

Could you say something about how you explain your cutting/ why you think you do it?

Are there common situations or feelings that lead up to the cutting?

Does the cutting change anything?

How do you feel about other people knowing about the cutting?

Why do you think other young people cut?

How do you feel about them?

Section 4: RESPONSE OF OTHERS

When you cut what do people normally do?

How do you feel about that?

How would you like staff to respond ideally?

How would you like other young people to respond ideally?

Looking back, say a week later, do you still feel the same way?

Section 5: SPECIFIC INCIDENT

Please think of a recent time that you cut yourself. I would like to ask a few questions about that time.

Could you describe what happened?

Why do you think you cut that time?

What did others do and how do you feel about this?

Why do you think you chose that time to talk about?

Section 6: OTHER SELF HARM

Do you harm yourself in other ways?

How do you think cutting is the same or different from overdosing? (or other harm)

DEBRIEFING

[RETURN TO ANY ISSUES THAT MAY NEED PASSING ON AND DISCUSS WITH THE YOUNG PERSON]

READ OUT THE FOLLOWING:

- Thank you for taking part in this interview. I hope that this research will help people to understand cutting in young people better. Before we finish, I have a few questions about the interview.
- How do you feel having finished the interview?
- Was there anything that was particularly upsetting or confusing in it?
- Do you think there were important things missing in the interview?
- Do you have any questions now about the interview or what I will do with the information?
- Is there anything that you have said that you would like me to change or remove?
- Would you like us to meet again when I have typed up the interview so you can check what I have written?
- If you think of any other questions about this research please tell your key worker and they will contact me. I will get back to you as soon as possible.
- I would like to send you a summary of this research when I have finished it. Would you like to receive a copy? I would be very grateful for any comments you may have about the summary.
- Lastly, we will now be meeting with a member of staff to discuss how the interview went. Do you have any questions about this before we go?
- Thank you for your help.

Record time interview ends _____

INTERVIEW WITH STAFF

Section 1: BACKGROUND DETAILS

Could you briefly describe how you came to be working in this unit.

How long have you been working here and in this general area?

Please could you explain what self-cutting means to you / how would you define it?

Approximately how often are you involved in managing incidents of self-cutting in this unit?

Section 2: EXPERIENCE OF CUTTING

How do you feel about working with young people who cut?

How do you feel about them when they cut or are about to cut?

How do you think the young people feel about their cutting and about themselves when they have cut?

Usually what do the young people do when they cut/ how and what with?

Section 3: EXPLANATIONS OF CUTTING

Could you say something about how you explain self cutting/ why do you think they do it?

Are there common situations or feelings that seem to lead up to the cutting?

In your experience, what sort of effect does the cutting seem to have on;

- the young person?
- other residents in the unit?
- you?
- the staff group?

Do you think that the young people want other people to know about the cutting?

Section 4: RESPONSE OF OTHERS

How do you respond generally to the young people when they have cut?

What sort of response do you think the young person would want ideally;
- from you?
- from their peers?

At the time of incidents how do you feel?

Looking back, say a week later, how do you feel then?

Section 5: SPECIFIC INCIDENT

Please think of a specific time in the last few weeks that you intervened with someone cutting. I would like to ask a few questions about this time.

Could you describe what happened?

Why do you think the person cut themselves that time?

How did you and others respond?

How do you feel about this?

Why do you think that incident came to mind?

Section 6: OTHER SELF-HARM

How do you think cutting relates to other self harm/ similarities and differences?

Section 7: DEBRIEFING

READ OUT THE FOLLOWING

- Thank you for participating in this interview. The aim of the research is to get a fuller picture of people's experiences of self-cutting. Before we finish there are a few last questions.

How do you feel having completed the interview?

Were there any particular difficulties that this interview raised for you?

Do you think there were any important areas not covered?

Do you have any immediate questions about the interview or what I will do with the information?

I will send you a copy of your transcript so that you can check it and make any changes you want to.

I would appreciate any feedback you might have about the research and analysis of results. Would you like to receive a summary of the results?

Do you have any questions?

Thank you for your help.

Record time interview ends _____

ETHICAL ISSUES

The research will follow the British Psychological Society code of conduct and the Division of Clinical Psychology Professional Practice Guidelines.

The ethical issues raised in carrying out this study and the ways in which they will be addressed follow.

1. Consent

- All potential participants will receive an information sheet prior to the study. This will outline the objectives of the study, what will be requested of participants and the procedure for participants to volunteer.
- A meeting will be held with potential participants to give more detailed information and to answer any questions participants may have.
- In order to address the issue of the researcher being in an authority position and any perceptions that participants may have about members of staff wanting them to participate, it will be stated explicitly that there is no pressure for people to participate.
- The role of the researcher and limitations to confidentiality will be clearly explained prior to agreement to participate (see section on confidentiality).
- Three separate consents will be required.
 1. Clinical consent will be sought from the Clinical Team. The consultant and key worker's written consent will be required. The consultant's consent will be taken to indicate that the opinions of clinical colleagues have been sought and agreement given.
 2. The appropriate parent/guardian/social services consent will be sought. The Clinical Team will identify the relevant person/s who should be contacted for each young person and a personalised information sheet and consent form will be sent. This will be a similar format to the Clinical Consent Form. Written parent/guardian consent will be required for all participants aged 16 years and under. For older participants, the Clinical Team will decide what is most appropriate on an individual basis.
 3. Written consent will be required from the young person. The consent form will include a further explanation of the study and the limits of confidentiality. It will be made plain that the participant may withdraw at any time during the study without giving a reason. If any participant leaves the interview room during the interview, no attempt will be made to persuade them to continue and their withdrawal will be taken as a withdrawal of consent.
- Transcribed interviews will be shown to participants who will be invited to check for accuracy and they will be informed that they may request that some or all of the data be destroyed.

2. Confidentiality

- The limitations of confidentiality will be made explicit before the interview. Information given by participants will be treated as confidential by the researcher unless it would be harmful or illegal to do so. If any information is disclosed that suggests that the participant may harm themselves or someone else or is being harmed, this information will be passed on to the relevant authority, in almost all cases this would be the Clinical Team. The participant will be informed of this and a permanent record will be made of what was disclosed, when and to whom.
- No individual names will be included in the write-up.
- Some verbatim quotations will appear in the write-up but the identity of participants will be disguised.
- Individual transcripts will not be shown to any other participants or members of staff.
- Raw data will be kept securely and only the researcher and supervisor will have access to it.
- All identifiable information will be destroyed on completion of the research.

3. Protection of participants

- The primary responsibility of the researcher will be to protect participants from harm during the study.
- Careful consideration will be given to any possible contraindications for participating in the research, for example psychosis. The Clinical Team will decide which young people are appropriate on an individual basis. The well-being of participants will be considered both at the time of recruitment and at interview.
- Potential distress caused by the interview will be addressed by: informing participants of the areas of questioning prior to seeking consent, allowing withdrawal at any time, setting in place a procedure for the participant to have access to support in the event of distress during or following the interview. This will be negotiated with the unit and participant and will involve the key worker or another member of staff being available during and following the interview.
- A link person will be identified on the unit. In the event of questions and concerns arising as a result of the interview, the participants will be invited to inform the link person who will make contact with the researcher. The researcher will make a pre-arranged follow-up visit to the unit.
- When asking personal questions, assurance will be given that participants do not need to give answers if they do not want to.

-
- It will be made explicit that the participants views will not be discussed with any adults on the unit.
 - Attention will be paid to the possible consequences of the study on the atmosphere in the unit, for example that only a sample of young people will be involved, that emotive issues about others in the unit may be raised.

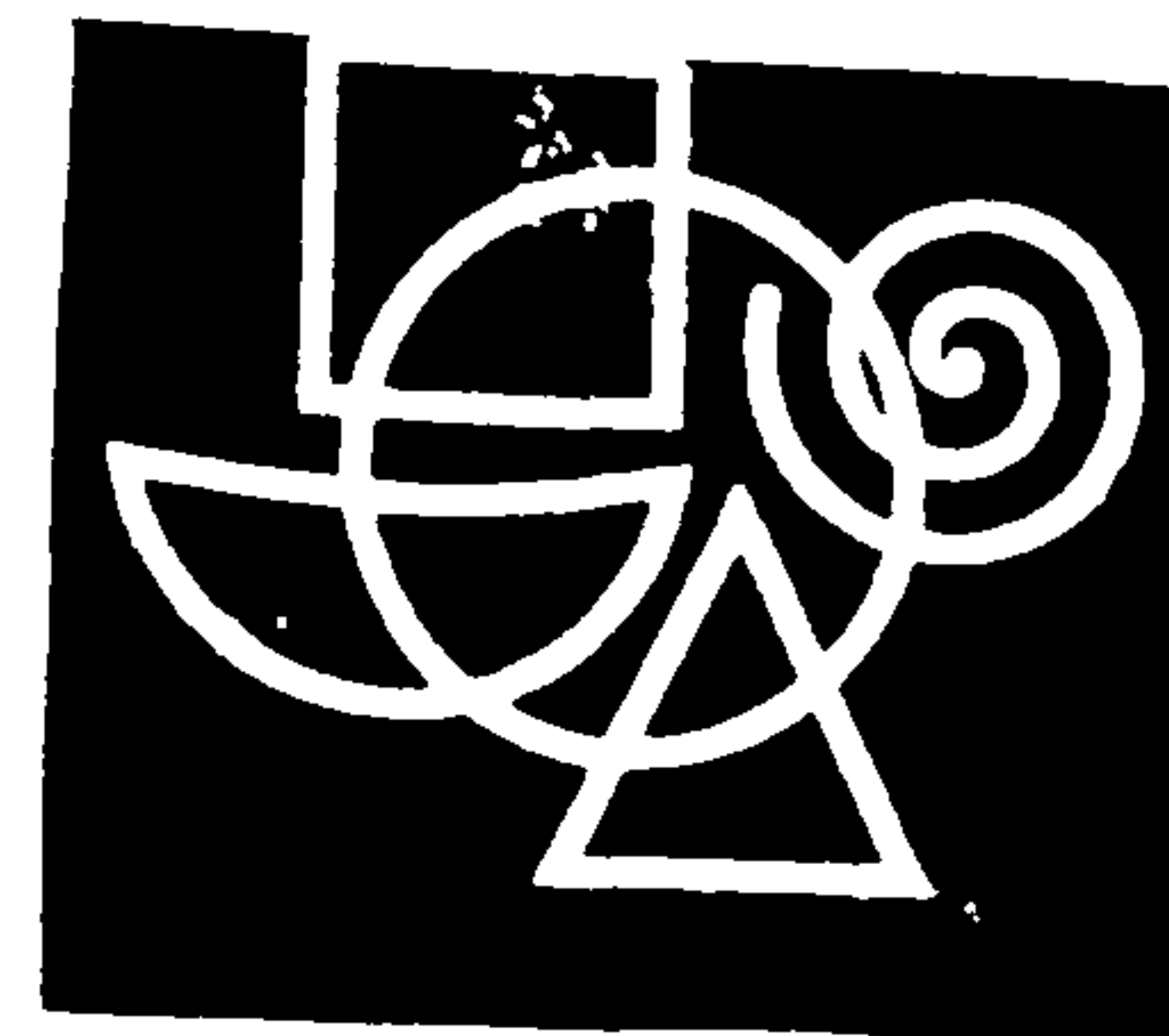
4. Debriefing

- At the end of the interview time will be left to discuss the participant's experience of participating and any further questions they may have.
 - As raised above, attention will be given to the emotional state of the participant following the interview. It is hoped that participation will be of value to participants. If no adult was present in the interview, a handover procedure will be in place which will involve the participant, researcher and young person and will allow the participants well-being to be ensured without breaking confidentiality.
 - Participants will be asked whether they would like to receive a summary of the research and this will be sent following write-up.
-

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SALOMONS
CENTRE

Ms V Norris
Trainee Clinical Psychologist
Salomons Centre

29th November 1996

Dear Vivien,

Re: *Ethics Approval*
"Adolescent and staff experience of self-cutting behaviour in residual settings - a qualitative study."

The Ethics Panel is pleased to provide full ethical approval for your research project. The Panel were impressed with the thoroughness of the proposal and the way in which the ethical issues had been considered and taken into account. It would, however, be worth considering carefully what you intend to do with the transcripts after the study has been completed.

We wish you well with the project and would be extremely interested to see the results.

Yours sincerely,

Dr A Lavender
Chair of Ethics Panel

INFORMATION SHEET

Self-cutting in young people

Researcher: Vivien Norris

If you would like to be interviewed for this research please read this form.

What is the research about?

Self-cutting is a confusing area and people have different opinions about why someone might cut themselves and what can be done to help. When a young person cuts themselves, the adults/staff and other young people have to decide what best to do. This research is trying to increase understanding about young people who cut. I would like to invite you to take part. I am interested in talking with people who cut themselves and people who do not cut themselves but have friends who do. I think your ideas and experience are very important.

What is the interview about?

The interview is about your experience of cutting; why you think people do it and how you think other people could help. I will ask you to think of a recent time that either you cut or a friend of yours cut and we will talk about this. The interview will last about one hour. You can stop the interview if you want to and can miss out questions if you don't want to answer them. You can be interviewed on your own or with a member of staff. After the interview we will have a short meeting with a member of staff to talk about what it was like doing the interview.

What is the point of this research?

I hope that this research will help people to understand cutting in young people better. I will be interviewing some young people who cut, some young people who don't cut and some members of staff.

I will keep what you say to me private unless I think it is harmful or illegal to do so. I will not pass any information on without talking to you first. No names will appear in the write-up and the research will not be in the newspapers or on TV.

If you are interested in being interviewed for this research, please could you tell _____ and she will let me know. I can then arrange a time to come and meet you.

Thank you for reading this.

Vivien Norris

INFORMATION SHEET - MEMBER OF STAFF

Title of Project Self-cutting in young people. A qualitative study exploring adolescent and staff experiences of self-cutting in residential settings.

Principal Researcher: Vivien Norris. Psychologist in Clinical Training

Outline explanation

Self-cutting is a confusing area and people have different opinions about why someone might cut themselves and what can be done to help. When a young person cuts themselves in a residential setting, the adults/staff have to decide how best to respond. This research is trying to increase the understanding about how young people feel about their cutting and to get a clearer idea about how adults might help. I would like to invite you to take part. Your experience as a member of staff working with young people who self-cut is very important.

What would be expected of you if you decide to take part?

All information for this research will be obtained from a face-to-face interview with me which will last not longer than an hour and a half.

What sort of information would I be asked about?

The focus of the interview is about your personal experience of working with young people who cut; how you feel about and make sense of it. I will also ask you to think of a recent incident of cutting that comes to mind and we will talk about this in some detail.

What are the aims of the research?

The main aim is to get a greater understanding of self-cutting in young people. I will be interviewing some young people who cut themselves, some young people who do not cut and members of staff to ask them how they feel about and explain cutting in young people. I hope that this research will have an influence on the way in which cutting is understood and managed.

Any personal information will be kept confidential, unless it is harmful or illegal to do so. No information will be described in the write-up of this research that could lead to your identification. If you agree to participate you can withdraw from the study at any stage without necessarily giving a reason.

If you are interested in taking part in this study please could you let _____ know and they will contact me. I am very happy to meet with you to discuss the study further before you decide whether to participate.

Thank you for taking the time to read this information sheet.

Psychologist in Clinical Training

CONSENT FORM

Self-cutting in young people

Researcher: Vivien Norris

If you would like to be interviewed for this research please read this form.

What is the research about?

Self-cutting is a confusing area and people have different opinions about why someone might cut themselves and what can be done to help. When a young person cuts themselves in a residential setting, the adults/staff have to decide what best to do. This research is trying to increase understanding about young people who cut. I would like to invite you to take part. Your experience as someone who cuts themselves is very important.

What is the interview about?

The interview is about your personal experience of cutting; why you think you do it and how you think other people could help you. I will ask you to think of a recent time that you cut and we will talk about this. The interview will last about one hour. You can stop the interview if you want to and can miss out questions if you don't want to answer them. You can be interviewed on your own or with a member of staff. After the interview we will have a short meeting with a member of staff to talk about what it was like doing the interview.

What is the point of this research?

I hope that this research will help people to understand cutting in young people better. I will be interviewing some young people who cut, some young people who don't cut and some members of staff.

I will keep what you say to me private unless I think it is harmful or illegal to do so. I will not pass any information on without talking to you first. No names will appear in the write-up and the research will not be in the newspapers or on TV.

I (name) _____

agree to take part in this research which has been properly explained to me. I have asked any questions I wanted to. I understand that I can drop out of the research at any time and do not have to answer questions if I don't want to. I don't have to give a reason.

SIGNED(Volunteer)_____ Date_____

Researcher_____ Date_____

CONSENT FORM - SENIOR STAFF ON DUTY

Self-cutting in young people

Researcher: Vivien Norris

_____ would like to be interviewed for this research today. The relevant permission for carrying out this research has been given. As the senior staff member on duty, please read this form and decide whether you agree to her participation.

What is the research about?

Self-cutting is a confusing area and people have different opinions about why someone might cut themselves and what can be done to help. When a young person cuts themselves in a residential setting, the adults/staff have to decide what best to do. This research is trying to increase understanding about young people who cut.

What is the interview about?

The interview is about the young person's experience of cutting or being around young people who cut; why they think people cut themselves and what they think a helpful response would be. The interview will last about one hour. After the interview we will have a short meeting with a member of staff to talk about what it was like doing the interview.

What is the point of this research?

I hope that this research will help people to understand cutting in young people better. I will be interviewing some young people who cut, some young people who don't cut and some members of staff.

All personal information given in the interview will be kept confidential, unless it is harmful or illegal to do so. No information will be passed on without discussing it with the participant first. No information will be described in the write-up that could lead to identification of participants. Anyone who agrees to participate can withdraw at any stage without giving a reason.

I _____ Date _____

as the responsible staff member on duty, hereby give my consent for

_____ **to be interviewed today.**

CLINICAL TEAM CONSENT FORM

Title of Project Self-cutting in young people who live in residential settings.

Researcher: Vivien Norris, Psychologist in Clinical Training

_____ (name of volunteer) has expressed an interest in participating in the following research project. Please could you read this form and decide whether you agree to their participation. Written consent is required from the consultant and key worker. The consultant's consent will be taken to indicate that the opinions of clinical colleagues have been sought and their agreement given.

Outline explanation

Self-cutting is a confusing area and people have different opinions about why someone might cut themselves and what can be done to help. When young people cut themselves in a residential setting, the adults/staff have to decide how best to respond. This research is trying to increase the understanding about how young people feel about their cutting and to get a clearer idea about how adults might help.

What would be expected of people who decide to take part?

All information for this research will be obtained from a face-to-face interview with the researcher which will last not longer than an hour and a half. Consent for participation will be sought from the Clinical Team, the appropriate parent/guardian and the young person. The focus of the interview is about the person's experience of self-cutting or being around people who self-cut; why they think people cut themselves and what they think a helpful response would be. There will be a debriefing following the interview. I will be interviewing some members of staff, some young people who self-cut and some young people who do not self-cut, but have friends who do.

All personal information given in the interview will be kept confidential, unless it is harmful or illegal to do so. Any information passed on will be discussed initially with the participant. Information that could lead to identification of participants will not be included in the write-up of this research. Anyone who agrees to participate can withdraw from the study at any stage without necessarily giving a reason.

We (Consultant) _____ **Date** _____

and (Key Worker) _____ **Date** _____

hereby consent to the young person named above participating in this research project.

CONSENT FORM

Self-cutting in young people research project

Dear _____

I am writing to you about _____

A research project is being carried out about young people who cut themselves and have agreed to take part. A few people will be interviewed, some young people who cut themselves, some young people who have friends who cut themselves and some members of staff. _____ has expressed an interest in being interviewed and the staff at _____ have agreed to this. Your consent as the _____ is required before any interview can take place. Consent will also be required from _____ and from the young person.

Please could you read the information sheet that is attached and then if you agree, complete and return this consent form. If you would like to discuss this research further, please contact _____ and they will let the researcher know.

I (your name) _____ hereby consent for

_____ to take part in the above research.

Signed _____ Date _____

Thank you for your help.

Vivien Norris

Researcher, Psychologist in Clinical Training

CONSENT FORM (STAFF)

Title of Project Self-cutting in young people. A qualitative study exploring adolescent and staff experiences of self-cutting in residential settings.

Principal Researcher: Vivien Norris. Psychologist in Clinical Training

Outline explanation

Self-cutting is a confusing area and people have different opinions about why someone might cut themselves and what can be done to help. When a young person cuts themselves in a residential setting, the adults/staff have to decide how best to respond. This research is trying to increase understanding about how young people and the adults around them feel about cutting in order to get a clearer idea about how adults might help. I would like to invite you to take part. Your experience as a member of staff working with young people who self-cut is very important.

What would be expected of you if you decide to take part?

All information for this research will be obtained from a face-to-face interview with me which will last not longer than an hour and a half.

What sort of information would I be asked about?

The focus of the interview is about your personal experience of working with people who cut; how you feel about it and make sense of it. I will ask you to think of a recent incident of cutting that comes to mind and we will talk about this in some detail.

What are the aims of the research?

The main aim is to get a greater understanding of self-cutting in young people. I will be interviewing some young people who cut themselves and some members of staff. I hope that this research will have an influence on the way in which cutting is understood and managed.

Any personal information will be kept confidential, unless it is harmful or illegal to do so. No information will be described in the write-up of this research that could lead to your identification.

I (name) _____

hereby consent to take part in the above investigation which has been properly explained to me. Any questions I wished to ask have been answered to my satisfaction. I understand that I may withdraw from the investigation at any stage without necessarily giving a reason.

SIGNED (Volunteer) _____

Date _____

Researcher _____

Date _____

APPENDIX IX - Examples of Categorised Data

(full data set available from the author)

Context - What, how, where and when?

Only a few extracts are included in the first section on context as there was significant overlap and repetition in accounts.

DEFINITIONS

yp - making it bleed, so it drips

yp - A scratch isn't a cut, blood would have to be running.

yp - Scratching if it doesn't bleed it doesn't count. The blood should run.

yp - Cutting is generally when stitches are needed. Superficial cuts I would call scratches.

st - Wouldn't include scratching as such. I think bleeding is an important part of the cutting process.

st - Cutting is a lot more than just scratching. I would call scratching superficial scratching (some just scratch) versus cutting where there's bleeding.

st - Anything from scratches with plastic to cut with blade needing sutures. I think the bleeding is very important for some of the patients.

WHAT USED/ WHERE ON THE BODY

yp - Glass and razors .. face, my stomach, my legs, my arms, all the way up on both sides

yp - Glass, plastic, razors. My arms, sometimes legs but not a lot. I've done my face before

yp - With cans and glass, razor blades if I can get hold of them. Now I normally cut myself from the wrist to elbow on both sides. Before I did it all over my arms, legs and stomach.

yp - Blades, cans. I started doing my wrist and the bottom of my arm, then I ran out of space and went to the top of my arms and then I went to my legs, all sides and different ways.

yp - *I use razors and glass. Cut my arms, stomach and top of legs.*

st - *Razors, glass, cans, safety pins, drawing pins.*

st - *Blades or glass are most common but we've had everything. The fore-arms is most common, the top most common for scratchers, serious cutters do both sides. As they run out of room they move to arms, legs, torso. Some you can tell how much they're feeling by the severity, eg arm or genital mutilation.*

st - *Anything sharp, lots of things. They find it and hide it in their room.*

st - *Everything is used, glass, plastic, tin cans (favourite at the moment), razor blades, plastic cups. Most often they cut their arms, all over then legs, stomach, breasts, thighs, genitals. Most common on their arms on the top and then inside. Sometimes they move from place to place to find new places when they've got lots of scars. Sometimes they cut down their cheeks, hand, neck, fingers, tips of fingers.*

PRIVATE / PUBLIC

yp - *Whenever it happens .. not in public, not in front of anybody. Mostly in my bedroom I think, and toilet so I can clean it up after. Unless it's really bad, then they'd have to get me somewhere and have to clean it up.*

yp - *I usually do it in the toilet, any time of day, normally late afternoon. I also went through a phase when I did it outside.*

yp - *Normally happens in the bedroom, bath is a lot of hassle and also I like listening to music when I do it. I've only done it in a public place once, in the park, 'because there was no one else around. I don't do it with others around*

st - *They do it in the bedroom or toilet really, unescorted outside sometimes as well.*

st - *It's a very private activity. It's private, it's extremely rare for people to do it publicly. It sometimes happens with one other person around but hugely it's retire to bathroom, or own room, or bedspace or whatever it is and it's quite a private and separate activity the actual doing of it. Then there's the displaying of it afterwards, almost like wearing the banners of I don't know, triumph or shame. There is often, though not always, the compulsion to show, at times there's the great long sleeves held down.*

st - Often in their bedrooms, safe place. They normally do it in a quiet place. Then we get to know about it later, they'll show you their arm or sit with blood showing.

st - They do lots of things to let us know, hide, play loud music, go a bit weird beforehand. You know when they've cut.

FREQUENCY

yp - I used to do it every week, now about once a month. I've calmed down because I've started to deal with my problems. We help each other here and sit together.

yp - About 5 times a day is the most because then you've got no room left on your arms.

yp - When I can get a chance. About a year ago, sometimes I did it 2 times a day, sometimes every night and sometimes I could last 2 weeks. If I'm feeling really bad that day then if I can get something I'd use it. It's difficult to get things here, I'd look for something sharp when I need it. I don't look the whole time. There's been times when I have been storing and that, that was ages ago.

st - On average maybe one a week but sometimes it's much more, like 5 times a day. Last summer we had a lot of cutting girls in, one cut often led to the others cutting. It does come in spates.

st - It varies from everyday to at the very least once a week. Some times are much worse than others, it depends on the way the unit is, what intense therapy the patient has been under, client group we have in at the time

st - Daily, someone's cut or redressing. At the moment it's a lot.

st - It actually goes through phases, at the moment daily. Unfortunately sometimes we have a lot of cutting and then not for a while, then we get a lot of swallowing. Sometimes it's the 'in thing', then smashing up. It happens daily for a month then it'll die down.

st - I suppose I might be involved in incidences about every fortnight - three weeks.

1) EXPLANATIONS

a) Intrapersonal explanations

(1) Survival strategy/ suicide

yp - I do it to keep myself alive, keep going, but sometimes I don't know what I'm doing.

yp - *That's the first one I did totally away from everyone. It's the first time I cut not really knowing myself, like jumping from the stairs and walking in front of cars. Instead of continuously walking in front of cars I cut instead. It's the only time I couldn't feel my fingers, at the time it didn't bother me.*

yp - *When you start it's not like you worry about how deep you cut .. then your arm goes numb and you go deeper and deeper you're going so you don't realise how deep you've gone.*

yp - *I do want to die but I want to be cared for more.*

st - *I think it's a way for them just to keep going, they're not trying to kill themselves, but then sometimes they're not really in control.*

st - *It was scary .. trying to patch people up ... seeing blood and blood everywhere. You never know at the end of the day, can only assume how far they'll go, especially if they're going through a stage of doing a lot. If something goes wrong, how far will they go? Fear that they'll go too far and not mean to. One day it will just go so wrong.*

st - *It was hard work because I felt a bit scared for her, especially with the needles. I felt with her that she wanted to die. Sometimes I feel that I wish they would. It would stop them thinking and feeling.*

(ii) General coping strategy

yp - *Because I don't know how else to deal with my problems. I either cut, take aerosols or run. It's a way of coping when I get really stressed out.*

yp - *I cut myself because she left but I had a lot of problems as well. I thought I could get everything out then by cutting. I knew that that was a time that I could get all my anger out rather than take it out on other people. If I cut then I wouldn't have to cut the next day because of something else. I cut for lots of things.*

st - *Lots of everyday situations lead to the cutting. Some people are better first thing in the morning, the time of day determines how they feel. Often early evening is the worst time. Events like meetings that are going on, or anything that involves being in a group situation, having to communicate, sessions that throw up emotions. There are lots of groups daily that bring up all kinds of emotions. They are very vulnerable at that time. Phonecalls, visits, it could be anything, really anything. The list could go on for ever.*

st - Just to cope. They don't have many resources and cut for loads of reasons.

(iii) Calm/release/distraction

yp - I bottle up problems, go too far, get too stressed and start hacking away. It calms me down, I do it to myself to feel more calm.

yp - Makes me feel good ... there's like you're letting off ... sort of like a release of something, takes the edge off the depression.

yp - At the time I cut it puts a smile on my face. I think for a split second you feel really good, then you've got the clearing your arms up and that. I don't bother, I just sit and wait till it stops bleeding.

yp - It makes me feel better at the time, then afterwards I cry 'because I regret it 'because of the scars.

yp - After I've cut I feel almost drunk. Makes me feel a lot better, kind of like a euphoria, lasts about 10 minutes. Then I get depressed again, worse than it was before. It upsets me a bit that I've got scars. The deeper it is, the more it bleeds, the more stitches it feels better. Each time to get the same effect you've got to do it more. It feels good to look at a fresh cut when it's bleeding.

st - After they've cut they feel better but there's guilt and shame in there along with it, but if you get someone to admit that it's a rarity. I know someone who looks like they are on drugs after they've cut, rush of endorphins. The need to cut comes back very quickly. The release is very short-lived.

st - I think there's an initial release, they actually feel relief of stress come out of themselves but later, especially when they're stitched up they're quite disgusted with the way their legs, chest etc look. Some people are quite pleased when the scars are healing but then cut again.

st - The experience I've had, the girls say they feel very contented for the short time after it's happened. Released something, like opening a can of worms and some come out. But it doesn't last long.

(iv) Self-hate/ punishment/ internalised anger

yp - I don't know why really, it helps me cope. Sometimes when I get really angry I carve things into my arm ... bitch .. angry with myself. I don't get angry with other people.

yp - Anger and failure. Self-anger or anger at other people, you take it out on yourself, get angry with yourself. Once you've cut yourself, you feel like you've punished yourself enough. I feel more angry towards my family now that I can't cut.

yp - Well I used to cut my stomach because I used to think if I looked really ugly no man would ever rape me and that .. because I hate myself and that's the only way of punishing myself and because I don't want to die there's nothing else I can do.

yp - It doesn't hurt, it's just like you don't have a care in the world, or like no one cares about you. I do it to hurt myself, sometimes so I can feel physical pain rather than just what's inside, because I feel guilty of some of the things that are happening in my life. It just feels like pay back time now. Punish myself. It never seems to hurt but when I've finished it hurts. I want it to hurt. It's not so much a relief. I never felt better afterwards, I had to do more, it never felt enough. Sometimes I used to just sit for 25 minutes and go over and over again until I had no skin on my arms. It's like there's nothing inside, I didn't feel anything. For me it feels like there's nothing there. I don't really care what I look like from day to day.

st - when the girls cut they're feeling really low, unsafe, out of control, powerless, no self worth, basically like it's all too much for them, they haven't got anything. They hurt so much that they hurt themselves, to see if they still exist, because they deserve it. Often they're very very low when cutting, feel shit, worthless, no good.

st - Feelings of sorrow, unhappiness, feeling wretched. Feeling dirty because of abuse, sad and rock bottom, hopelessness, can't get out of that spiral, trapped.

st - I've found that every single one of the kids I've been involved with have been sexually or physically abused. One of the common comments from individuals is that they're so disgusted at themselves for what has happened to them that they feel so ashamed of their bodies that they have to destroy it. They don't care for themselves and do what they can to destroy themselves. They don't know a healthy way to express emotion. The only way they can express how they feel is to cut. They won't let you near them emotionally, it takes years to build up trust. They're severely damaged.

Re-enacting abuse

st - I came in and everyone was milling around. You just wanted them to go back to bed but you know what it was like, lots of excitement and one of the residents 'looking after' her. I told her we had to go to the hospital. She was incoherent but refused to go with anyone except for (male member of staff). I said no. I think it's interesting who these kids tell about having cut, I mean the sexual element was very clear and there was no way I was going to agree. But then, it was late at night and sometimes it's easiest to take the path of least resistance. But I said she would have to go with ... (female member of staff) and eventually we coaxed her. With this young woman there seemed to often be a kind of re-enactment of something, so that she would cut badly but refuse help except from her special male member of staff.

st - It's important to connect it with sexual abuse. It occurs much more frequently in young women who've been sexually abused and this is part of societies gender constructs, young boys are delinquent, young girls take the same psychic material and convert it to self harm.

(v) **'Making Concrete' - Getting bad things from the inside to the outside**

yp - I remember going out and someone saying to me, you know, why are you in hospital, everyone gets depressed. Just questioning me, questioning whether I was being a premaddonna, then I needed to prove to myself that I wasn't. People can't understand being depressed, they just think it's glorifying self-pity. I've heard lots of reasons why from other people and I can relate to them. It definitely helps in part of my depression which is insecurity, not knowing who I am. It helps to cut that deep to show that you have got depth to your feelings and that whatever you've got, you're real.

yp - It's funny, it's sort of, it hurts and you think, my God that hurts, but it's hurting somewhere else, but it doesn't hurt your soul, your heart. It's quite localised, the pain, it's quite easily bearable. I always do it until the pain makes me feel sick then I forget what I was initially pissed off about. Simple displacement. It feels like a relief, swap one pain for another and normally that other pain won't come back if you keep doing it. It'll die it's death and won't come back again until there's another reason for it to come back.

yp - I feel different afterwards, feels like you've done something, don't feel so helpless anymore, you've done something. If I'm really down about something cutting makes me feel happier, come out of it. If I feel low, I cut and my mood lifts. Cutting my arm is the type of pain I can control, can stop and start. I can't do that with the pain in my head.

yp - It makes things more certain. I can think clearly up to before the point, after I can't think of what happens so it must be a kind of nothing. Just get on with things again.

yp - I suppose I've talked about self-hate. Not feeling a part of things and then I cut and I do distance myself from other people, representing the gap I feel. I feel this gap between me and my friends so when I cut I create a gap again. It's nice to tie things down. Things are less questionable, things become more secure, you can feel the gap and show the gap. All the time it's just a thought in the head it can be questioned or changed.

yp - It feels good, it makes me feel better. It's the type of hurting you can control. Sometimes I don't feel any pain, other times there is pain but it doesn't feel like pain, doesn't bother me at all.

st - For some of them it's a lack of self-worth. They're 'damaged goods' anyway, maybe they've been abused. They take the pain away from the heart and that's much more understandable. Sometimes people feel that getting the blood out cleans out the badness and it also lets them be looked after. It's saying, this is not normal, I need help, I'm not coping.

st - Normally these kids you know they're strange on the inside but they look OK on the outside and when someone's done that they don't. Summer comes and it's hot weather and then you're really faced with a choice, a lot of people are then covered up. I think that thing of covering up, having something to cover up on the outside as well as on the inside, marks of shame, violation and abuse, and it is a self-abuse, I think that's a very interesting term for these kids, and I think that's where the roots of the connection with sexuality and so on comes back. There's a symmetry, perhaps a sense of satisfaction, a sense of rightness then that there's something wrong with them on the outside.

st - I think cutting makes everything more definite, something to focus on rather than just feeling in a mess.

b) Interpersonal explanation

(I) Communicating level of distress - this is how much I'm hurting

yp - Sometimes it's my way of talking to people, a way of saying things aren't going well at the moment or I feel bad. Sometimes when I cut I can't talk, for example if I come back from leave, I can't get it out so I cut. Even when I've done it I still can't talk about what's happened, can't get any words out after. Sometimes I can talk about things.

yp - I feel that they should help me and around certain people I hide it because I feel stupid. Then other times I want to show them how much I'm hurting.

yp - I suppose I want nurses to know, to know how I feel so they can help me feel better, so they can make me feel special, understand me, so I have to give them the closest picture.

st - You've still got a chance to interact...it's not withdrawal. They're attempting to engage you in something... as if there's still a chance of a productive road (unlike suicide).

st - Sometimes it engages staff in caring behaviour and is an opportunity to speak with the person. In a sense it's quite an efficient method for staff to give her care.

st - Other girls do it to be cared for, 'will you walk away from me?'

(ii) Punishment of others

st - Anger, worthlessness. Things that spark it off could be an argument, setting boundaries and their way of pushing it is to cut. eg if they're angry at the primary nurse they will cut to get at them or their parent. Most of them would deny this.

st - They might be angry at the person that abused them 'look what so and so's made me do, they've put me through all this'.

st - She was upset and angry with the way staff had managed her. She was acting up, pushing boundaries and it was badly managed, they confronted her and the situation exploded. She went and shut herself in her room and cut her legs. She was angry with staff and was punishing them.

st - They also do self-harm to say 'see what you've done to me'.

st - Being in this environment they need to get out, feel free. We're closing them in a lot of the time. If they can't get their own way, for example a girl would want a cigarette, she'd say, if you don't give me a cigarette I'll cut, and she'd go and do it badly, like blackmail and all the time. That stopped when we ignored it.

st - It's taking the form of a quite deadly game. Don't think it's about dying..but I think that it's a possibility if you just deal with the behaviour...shoving it into a corner. Escalating seems to be in response to people trying to stop it. Like an awful game of catch me..we can't.

yp - Girls do cut to get back at staff but they wouldn't admit it because they'd feel even worse.

(iii) Attention/ status

yp - Sometimes it felt like some of them just did it like it was a trend for everybody. Some people did it for attention, but it's no way to get attention. I don't think it's funny. It makes me angry. I suppose that's why staff see it as a game, because everyone seems to do it, not just one. The majority of the girls in the younger group really get to me because they go round boasting about it and then show their sleeves to anyone and everyone because they see it as funny. I take it seriously. It's like every time I keep trying to prove a point to the staff,

yp - Some do it as a game. There was one time when 4 people cut each other, 11, 12, 14 and 15, they all cut each other. Everyone has been cut at some time. Some 10 and 11 year olds just do it, they just sort of cut. Lots of people start cutting when they get here. For some, they see other people coping like that and they do it too, and others it's just a game.

st - Also it's like a fashion accessory, they all do it and it's superficial, it looks good. Some young women come in and have never done it before and then in 4-5 months they're cutting too.

st - There's a role model for others cutting. We always find a kid who's 'top dog' in the unit and they act as the leader of the pack. Sometimes other people follow the lead and someone who has not cut will say I feel like cutting. It goes with the client age group. A lot are older, 16-18 year olds. They have joined together and tend to feed off one another, follow each others lead.

st - It has a knock on effect. If you've got a group of cutters, one will cut and they'll all cut. It's kind of infectious, like a rivalry. If one does it then the one who hasn't cut gets angry with the one who has and gets into the cycle.

st - We have competition cutters, the biggest cuts gain the most respect, they want sympathy and respect. But the others, most of them, don't want their peers to know that they've done it, just to be left alone.

c) Types of cutters?

yp - The copying ones I think are stupid, they're fucking their arms up for nothing. The others I feel sorry for 'because of the scars. They've got a lot of problems and might think that's the only way to deal with it.

yp - There are some people who just mess around cutting, just do it to copy other people and people who scratch instead of cutting are not the same. I think is of the same mind, she cuts very deep. One girl cuts in front of people, I don't understand that at all.

yp - Some of them do it for attention, especially here, but some of them don't. Like they show their arms off all the time and pretend they didn't know they were there. I have a go at them when they do that. Some of them don't cut when they come, then they start. Some of them I can understand and some of them are copying.

yp - Same reasons as me, low self-esteem. Just wanting to hurt yourself 'because you can't hurt other people.

yp - I get really pissed off with them, they go around saying I've cut, I've cut and go around showing their arm. I feel all right about the others, it seems normal really.

yp - Some people do it for attention sometimes and then when staff think they're doing it for attention, they're doing it because they really hurt.

st - Abused or fashion. The majority of bad cutters I've come across have been abused girls. Most of the boys I've known it's been quite fashionable, like that pop group.

st - I think there's 2 groups and probably millions in between. The predominant group are cutters who say for god sake do something about this, walking around dripping, with millions of razors. The others who hide it just need to self-punish badly and the longer

they go without dressings the greater the chance of infection, which is good for them, takes the self-punishment further.

st- Some people do it to get attention from the staff and are really dramatic, dripping blood around the place, they really get on your nerves. Others just go away quietly and they really hurt themselves, it's sad.

IMPACT OF CUTTING/ EMOTIONS EVOKED IN OTHERS

(I) Fear and anxiety

st - At the beginning I felt shocked and panicky, anxiety that I wasn't dealing with it right. I spent a lot of time with one young woman, 2-3 hours going round and round in a circle and getting nowhere and I learnt a lot from this. I wasn't clam at all, the young woman saw it and played on it.

st - When I first worked with it it was quite frightening because of not knowing how they were feeling at the time and how deep they would cut. It was scary to start with .. trying to patch people up.

st - I feel such a high level of concern that I can't think, overwhelmed by my feelings.

yp - I just have to go away, it really upsets me when she does it.

yp - It gets to me when someone else cuts, I don't know why, it just does.

(ii) Sympathy and concern

st - The impulse is to tend to, to nurse, to save, to make better, you've got to look after her, you mustn't be horrible.

st - feeling sad that someone has to find such extreme and mutilating way of dealing with themselves, their pain.

st - Sometimes it can be a feeling that I just want to wrap this person up in cotton wool and take their pain away, why is there that need, what are they getting out of it? You know it's about to happen, you get to know them and wish to wave a magic wand.

yp - Sometimes I just sit with them and look after them, I think we're good at looking after each other, we know what it's like.

yp - We make a pact that she won't cut and I help get her sorted out.

st - Another way young people deal with it is taking control over it...a mirror or parody of what they see staff doing. An attempt to say.. 'I'm looking after her .. we've had a long talk and she's promised me she won't do it again because she knows how much she hurts me'. Feels shallow but an attempt of others to do something.

(iii) Confusion and Impotence

st - One young person I eventually feel angry with...not aggressive, more..impotent and frightened. What are we doing..we don't seem to be helping. When there's extreme self-harming, all the time, every week, hurts herself significantly, I feel deeply sad about that.self-questioning, wonder what to do. Out of energy towards her, emotional energy, creative energy.

st - It triggered off very powerful feelings for me about my impotence to help this young person. I find she explodes boundaries all over the place..giving bits of information. 'Can I trust you to look after me. I'll tell you something big but you mustn't tell ', like a testing out. Needs to know where the lines are drawn, what's appropriate. By the very nature of the job you're looking to help keep people safe. This is patently saying you're not doing it. I don't think it is the case but sometimes it seems proof of your inability to keep them as safe as you might want to.

st - I've tried a lot of approaches over the years to get to where I am now. Nothing has made a lot of difference

st - When it really does distress me is when I've done individual work with the patient, then go in the next day and find that they've cut all night. Wonder why when they had plenty of opportunity, you feel useless I suppose, 'I've done a lot of good there'.

yp - Leave them to get on with it. Sometimes I say to (young woman) if I see that she's going to cut 'don't do it too badly', there's no point saying don't do it. She sometimes cries after she's done it. You just make enemies trying to stop people.

yp - Just keep out of the way, it's none of my business.

yp - You can't stop anyone cutting so I don't bother trying.

(iv) Anger

st - Often angry at them 'because you sit there and say just come and tell me when you want to cut. You're angry that you can't help. Sympathy went out the window about 2 months after having come here. You can't make things all right. Almost anger at

yourself, you always want to help them more than you can. No one can change a kid that doesn't want to be changed.

st - Furious, enraged, want to attack them further, horror stricken, very frightened and very anxious. Fury is a good one, a part of me is really furious.

st - It makes me feel angry. I feel that I'm being invited to engage in something that has elements of drama and performance and I think my anger comes from my resistance in being involved in this activity. It sets up a bit of a conflict in me. Part of me thinks cutting is motivated by unconscious things which are out of control of the people who are doing it but another part of me thinks that there's something more deliberate about it which is not about attacking their own internal world or conflicts but about imposing that conflict on the people around them. I think it's something which in my experience always involves an audience at one level or another.

st - There's only one that really gets to me and that's because it's so serious. It brings up a lot of anger in me - 'what the fuck have this family done to her to make her be this way'. Then when she spoke to me about the abuse I thought, her self-harm is nothing, she should be doing something much more than this. It is awful. Out of all of them she is the one I worry most about, she's really there to hurt herself and we haven't had much impact on her.

st - At other times I've been so bloody angry when they've been through it time and time again, not angry with the young woman but angry with what they've been through. When you get a young woman on the phone to her family who're being totally unsupportive, saying 'get your act together', and then you're left trying to pick up the pieces when she'd cutting herself afterwards, I feel very angry then.

st - I worked really closely about a year ago with an abused girl. She was very pretty, lovely girl, she cut her wrist and that. One night I was checking her and I walked in on her and she cut her chest really badly, scarred for life. It was horrific 'because she'd been abused and my anger was 'why has he done this to her, she's taking it out on herself'. Because she was so pretty as well, I felt so angry with him.

st - They don't acknowledge the effect they have on everyone else, it's very selfish and self-centred. But I don't think that's the intention. Until they come to places like this they're not aware of the effect it has on other people. They'll often say it's nothing to do with anyone else. One girl last week was given a can by a boy and then she cut and blamed him.

yp - Some of them cut their arms because others do. I don't know whether they think it's a way of getting attention because you don't get much attention. It really annoys me, makes me angry. It's like when one person does it they all have to do it. They think I'm in here being asked what's up. I'm not, I'm being bloody shouted at. It's not a good way to get attention, they should know that.

yp - It really pisses me off because they just want attention.

yp - She's not a proper cutter, she just messes about showing off all the time.

(v) Cut off

st - we don't have normal reactions at all. It's quite worrying how we've managed to normalise this. They come to you, you wrap them up in bandages and it's like serving dinner. Every new staff who comes in, they're traumatised for 6 months and then it's like serving dinners, then you make jokes about it. It's a coping mechanism, that 10-15 year olds are slicing up their body and you can't do anything about it. The younger the cutter the harder it is. 'Brain meltdown', laughing is the only positive way to cope with this. Anger is well-buried. You have to learn to cope, to say it doesn't bother me. You can't crack up every time a kid cuts, whilst you're cleaning up you might be restraining in the next 10 minutes. You can't afford to feel anything.

st - I suppose I feel quite complacent, it's going to happen. If you take the glass away they'll find something else. It's not that I don't care, but there's not a lot to be done about it.

st - don't ever feel uncomfortable about self-harmers, have to stay detached personally. It used to scare the life out of me, gaping wounds. Now it doesn't affect me in the same way, horrible sight but you just deal with it. If you get emotionally involved in the whys and wherefores of what goes on you're going to crack up. We need to be strong for the kids.

yp - It doesn't bother me, I just keep out of the way, let them get on with it.

yp - Just ignore them, you get used to it, it seems normal really.

3) RESPONSES OF OTHERS

a) Staff responses to cutting

(i) Practical care/repair

st - I can deal with it afterwards, clear it up, you can mend what's been cut, can see it to deal with it. I can sit when a girl's cutting or whatever, I have sat with a girl who tried to cut her throat with glass, or someone who put a razor blade into their veins and got it under their skin. I don't like over dosing because I can't see it to deal with it. You can patch up, clean cutting.

st - It's not an issue that bothers me, I can deal with blood, poo and sick ... I can always put it back together a bit, clean it up. Maybe that's just my way of dealing with it.

st - There's something nice about cleaning people up. A lot of our job is very grey. It's quite nice sometimes to do something with them, clean them up, nicely bandaged arm, then they might trust you enough to tell you why. I use them a lot to assess their own safety, do

st - We don't do much else putting back the body things. I quite like to tidy people up a bit, make them feel cared for.

st - I take care of their wounds, make sure they are clean, and take care of their future safety. My way of saying I do care about what you do and are feeling but I'm not going to feed into it.

st - I normally clean up first, but don't like to reinforce the behaviour so just respond with the medical stuff and go and fill the incident form.

st - Some staff have said they're quite rough with people, when stitching them up.

(ii) Engagement/ Rescue

st - To be there or when they tell me to show warmth. Try to be supportive and empathic about how they're feeling. Check it's clean and covered, bandaged or whatever. Lot of concern around. I often pick it up later with them. They can spend time reflecting how they feel, for example, write about it. Let them know we're there to work through that with them rather than wait until they do it again.

st - I think it's all part of the process the young women are going through. It can be very painful to sit down and watch a young woman do that to herself but for me it's about trying to stay with that. Talk them through that until they're able to say 'I've done enough' and are able to hand pieces of glass or whatever over. I'll stay with it if I'm needed. I'd rather sit with them when they do it than let them be on their own. I don't enjoy it .. it's pretty horrible watching the, especially when it's quite deep.

st - I just feel like taking all the pain away, trying to really understand, talking it through. You can have some really intimate conversations.

(iii) Staff conflict of opinion

st - Sitting up and talking for long periods of time is bad, it ends up in a pattern. There's something in it for the staff who do that. For example there's a staff member attached to one girl who has done a lot of work with her. She would sit for hours with this young woman. It's not healthy, then the staff are like kids too. I'm very good at settlingat bed times, and bed time is a difficult time. They know the routine with me. But one night because this member of staff was there, she sat talking with one girl and they weren't going to bed. She said she wants to replace the abuser. But I said she's here for all the

girls, not just one. Now when this staff member is on the girl feels she can act out, put food on her. I knew it would backfire but the staff member gets so upset when the girl is angry with her. I sit there and I think 'what the bloody hell are you getting out of this?' I care about the girls but then I back off. If they give me a hug I don't like, I'll tell them it doesn't feel good. I'm here to look after the girls but not to re-enact abuse. Getting sucked into relationships is abuse. I don't worry about the girls. I worry sometimes about the staff.

st - Brings different opinions out in the staff group. Some people define cutting as attention seeking behaviour. I personally dispute that. My opinion is that it isn't attention seeking behaviour. This does cause problems among the staff. I may get angry with the person but not because it's attention seeking. There's conflict with other team members about whether people did the right thing.

st - People don't agree, everyone thinks their way is right. It does piss me off when people sit for hours talking to kids. It makes it worse for everyone else because the kids play off it and you're seen as really mean.

b) Young people's experiences of responses

(I) Ambivalence about being cared for

yp - Good that staff talk to you .. shows how much they care doesn't it? I want them to talk to me when I'm calmed down, not straight away, just want them to leave me for a while. When I'm stressed I want to be on my own.

yp - We need space. In a way I want someone there with me to protect me but then again I want a bit of space.

yp - To just keep an eye on me I think. That's a hard question that is. I think I'd want them to keep an eye on me at the time and if I didn't want them there I'd tell them to go.

yp - I'd want to know that they're still there. When the staff are here I always do it in my bathroom .. so they wouldn't come in. Don't choose to do it if staff are around, it just happens.

yp - Nothing. I just want them to leave me alone. Piss off and get out of my fucking way. Or let someone I like sit with me for a little while.

yp - One of the characteristics of people who self-harm is that they have the capacity to worry about other people but can't about yourself. eg. (young woman) looks after other people but is abusive when people try to look after her. I feel abusive too because you feel they shouldn't like you or care about you, it's also like extending your family, more guilt. In a 'hate world' it would be easier.

yp - They wouldn't leave me alone and that really pissed me off. I had to give the glass in otherwise I wouldn't be allowed in my room. Staff stayed with me till I was asleep and that pissed me off even more, because I'm not used to people caring that much and it scares me when they care because I think I'm going to get hurt.

yp - I suppose for them not to respond. It bothers me if they get upset.

yp - I want to be just left. In my old children's home they didn't really care, if you cut you just cut. Here they care too much, I get scared when people care.

(ii) Staff don't care and punish you for your feelings

yp - I listen to what people say time and time again. Even if people say good things I don't feel it. I'm fighting with myself. It's like I feel they're saying what I want to hear and that they don't mean it. Like I said to (member of staff) that I felt awful and that I cared about her and she wrote to me then but she wouldn't have thought of it. It's like being a page in people's diary. But I suppose no one is dumb enough to look after me unless they're being paid for it. I don't think anyone would do it unless they were being paid to do it. It drives me to insanity.

yp - Sometimes when someone runs off and they get stressed they take it out on one of the other kids. When staff are having a bad day they make everyone else's day bad. It is a punishment, being punished for the way you feel. When they strip the room they search everything and dump it in black bags. They don't do it neatly. If it was to keep us safe they would make sure there's nothing there and if they find something lock it up, they would leave your belongings. Locking up your belongings is a punishment.

yp - It just makes me remember how much the staff don't fucking care. Even when I do OD or bang my head they just say it's a waste of time. They're just here for the pay check. I can't stand people being paid to look after me. I want to be looked after by people because they want to.

yp - I just feel that if some of them have been threatening themselves, it's hard to get people to listen. They just don't want to know, say it's a waste of their time, that we're playing games. This word 'play games' makes you feel even worse. So you think 'I've just cut myself up so you can have a laugh'.

(iii) Do nothing

yp - Try and steri-strip it, dress it. Just the practical nursing thing, open wound, wrapping it up. Other than that people don't really know what to do. There's not much else they can do. If I wanted to stop I suppose they could help

yp - When I cut I don't want anything, leave me alone, go away. If they tried to stop me I'd cry and shout at them. I feel the same way afterwards.

yp - *Never want others to know , wish everyone would just leave me alone.*

yp - *Nothing, leave me alone.*

(iv) Accept/normalise cutting?

yp - *Don't know. I just want them to help me feel normal, then I wouldn't have to display my outrage at not being. Just understand.*

yp - *Everyone's got a right to do what they want.*

yp - *I want to try and beat it myself. Not sure if I want to stop. I definitely want to stop where people can see 'because then so many people can't empathise with it, they see scars and see you like an alien and to some extent you are.*

yp - *It seems normal to me. They should leave us to get on with it. But then I suppose you might think they didn't care.*

st - *One girl couldn't believe that we bothered so much about her. And when for example they took her aerosols away she said 'the staff do care about me'.*

(v) Prevent serious damage

yp - *Here they're not allowed to physically stop you unless you're doing something completely insane. But in hospitals they're there to stop you .. a bit of relief that someone can stop you and at other times you just wish they would bugger off. Sometimes you have control and can stop .. but other times you just wish someone would stop you because you can't stop. But people can't read minds.*

yp - *I couldn't feel some of my fingers then. They just brought me back, stitched me up, that's it. I didn't feel like talking. They couldn't have left it, thinking about it now, they just said it's lucky someone who was passing knew you.*

yp - *They should stop people if they're doing serious damage but if doing superficial cuts, no. Staff should watch them .. check they're all right. Staff could walk away if you're doing really deep cuts and then come back and find they're dead. I've had staff sitting in here when I've been cutting. You can't stop someone from cutting.*

SUMMARY OF RESEARCH - YOUNG PEOPLE AND CUTTING

Most young people thought that cutting was different from scratching. Cutting meant that blood flowed and a scar was left. Some people thought that deeper cuts were better.

Different things were used to cut, glass, razors, cans etc. and different parts of the body were used, the arms were the most usual. Almost all cutting happened in private, in people's bedrooms and bathrooms. People said they sometimes wanted staff to know but that often they just did it on their own.

EXPLANATIONS Why cut?

Different reasons were given. Almost all young people saw cutting as a way of coping and not as a way to die but a few said they sometimes felt suicidal and thought they might go too far when cutting.

1. **A general way of coping**

People said there were lots of reasons why people cut and they were different for different people.

2. **Calm/ release/ distraction**

A lot of people said the cutting gives a quick release and takes attention away from problems and stress. The relief doesn't last long and then the feelings come back. Some people said they feel ashamed and guilty after cutting.

3. **Self-hate/ punishment/ anger**

A few people talked about feeling awful about themselves and then cutting because they think they deserve to be punished. Also when people feel angry with others they take it out on themselves.

4. **Getting bad things from the inside to the outside**

Everyone said that cutting takes bad and confusing feelings from inside the person and makes them into something definite which feels better. It also proves how bad someone feels. Some people felt pain but most said that they could control it which was important.

5. **Showing others how bad they feel**

A few young people said that cutting was sometimes a way of talking to people and showing them how bad they're feeling.

The last explanation for cutting came out when young people were asked why they thought other young people cut.

6. Cutting for attention

People thought that there are 2 types of cutters. Some people cut as a way to cope with awful feelings and everyone who was interviewed said that they cut for these reasons. Other people cut to get attention or to copy others. People might cut sometimes for attention and other times because they feel awful and then staff don't understand.

CYCLE?

Everyone said that cutting only worked for a while and then the stress and problems came back and they had to do it again.

FEELINGS ABOUT OTHER YOUNG PEOPLE WHO CUT

People often had strong feelings when other people cut. these were:

1. Sympathy

This led to helping the other person

2. Anger and annoyance

This led to getting angry or ignoring the person

3. Upset

This led to feeling bad and wanting to cut yourself as well

Most young people thought that if they cut it was no one else's business and other young people should keep their noses out. Some people said they didn't want other people to get upset when they cut because this made them feel guilty and want to cut more. Everyone got angry when other people copied them because it made them look as if they were 'only cutting for attention'.

FEELINGS ABOUT HOW OTHER PEOPLE DEAL WITH CUTTING

1. Mixed feelings about being cared for

People gave a lot of mixed feelings about what they wanted from other people. They wanted staff to be around and said that staff talking to them showed that staff cared but they also said that staff shouldn't interfere. People sometimes wanted their friends to sit with them but also to be left alone. Some people said that being cared for was too scary because they weren't used to it and might get hurt.

2. **Staff don't care**

Some people said they didn't feel that anyone really cared for them.

3. **Do nothing**

Most people thought that their cutting wasn't really anything to do with other people and that people should do nothing except maybe check they're OK and help with bandaging. They thought that no one could stop anyone cutting until the young person wanted to.

4. **Prevent serious damage**

Almost all young people said that staff should stop anything really bad from happening and that it made them feel safer when staff were around.

SUMMARY OF ANALYSIS

Context of cutting is described

The themes and subcategories that follow include verbatim extracts.

1) EXPLANATIONS

a) Intrapersonal

- (I) Survival strategy versus suicide
- (ii) General coping strategy
- (iii) Calm/ release/ distraction
- (iv) Self-hate/ punishment/ internalised anger
- (v) Concretisation - bad things from inside to outside

b) Interpersonal

- (I) Communicating level of distress
- (ii) Punishing others
- (iii) Attention/ status

c) Types of Cutters?

2) IMPACT OF CUTTING ON OTHERS

- (I) Fear and anxiety
- (ii) Sympathy and concern
- (iii) Confusion and impotence
- (iv) Anger
- (v) Cut off

3) RESPONSES OF OTHERS

a) Staff responses to cutting

- (I) Practical care/ repair
- (ii) Engagement/ rescue
- (iii) Staff conflict of opinion

b) Young people's experience of responses

- (I) Ambivalence about being cared for
- (ii) Staff don't care
- (iii) Do nothing
- (iv) Accept/ normalise cutting?
- (v) Prevent serious damage

ANALYSIS

The analysis is organised in the following way. First the context of cutting is described, how it is defined, how and where it happens. This is followed by an examination of the three main areas of analysis; (1) the explanations offered for the behaviour, both those that attribute it to processes within the young person and those that consider interpersonal issues; (2) the impact cutting has on others and (3) the responses to cutting and how these are experienced by the young people. The accounts given in each of these main areas have been organised into themes and illustrations of verbatim data are given. Extracts are in italics and prefaced by 'yp' (young person), or 'st' (staff).

Context - What, how, where and when?

With a few exceptions, young people and staff agreed on definitions of cutting. 'Cutting' was distinguished from 'scratching'. Scratching was seen as making superficial marks whereas cutting involved blood flowing. Scarring was consistently mentioned as important. Deeper cuts were seen as better, suggesting a hierarchy of seriousness. The idea that some cuts are better than others permeated through the study and into views regarding whether other young people were seen as 'real' cutters. All the young people interviewed saw themselves as people who 'cut' regardless of severity.

A wide range of implements were used and particular implements were popular in the different settings. The areas of the body cut ranged from the outside and inside of the lower arm, which was said to be most common, moving to the legs and less frequently to the stomach, face and in one case genitals. Several people moved from arms to legs when they had 'run out of room'. Many descriptions of the act of cutting referred to the use of ritual such as using music and adopting particular rules, such as only being able to use a particular blade if no one knew about it then having to discard it.

Cutting happened almost exclusively in private, in bedrooms and bathrooms and at times alone outside. The issue as to whether cutting remained in the private arena raised differing young person and staff views. Young people saw themselves as involved in a private activity where contact with staff primarily arose from the need for practical care, bandaging and stitching. Staff in contrast saw cutting as involving many public aspects such as the frequent display of wounds following cutting and ways in which the young people let staff know that they had cut. The private/public issue raised conflicting opinions and young people also showed significant ambivalence in their behaviour by for example hiding in their room and barricading themselves in while also playing very loud music. It appeared that when the accounts of what is happening move towards interpersonal issues, the gap between young person and staff experiences widens.

Young people and staff saw the frequency of cutting as varying across time and within individuals. Young people said they cut from 15 times a day to once a month and were primarily influenced by mood and opportunity. Staff reported being involved in incidents from several times a day to once a month. The young people and some staff thought that a lot of cutting goes undetected.

1) EXPLANATIONS

A wide range of explanations were given. These divided into (a) intrapersonal and (b) interpersonal explanations. Young person and staff explanations predominantly involved processes that were going on within the young person. Young people almost without exception saw their cutting as an internal process. They did however see some other young people as cutting for interpersonal reasons and many comments were made about different 'types of cutters' (c).

a) Intrapersonal explanations

(I) Survival strategy/ suicide

Cutting was overwhelmingly experienced as a short term way of coping with unbearable feelings of anxiety, depression and anger and not as a means to die. A few young people however expressed suicidal feelings at times of cutting and on occasions some young people and staff were very concerned about the level of harm that might be inflicted particularly when young people were in a dissociated state and did not appear to be in control of the degree of harm.

(ii) Way of coping

Cutting was seen as a general coping strategy from a limited repertoire of responses which involved doing something.

(iii) Calm/release/distraction

The predominant explanation of cutting was that it provided relief and distraction from overwhelming feelings and had a short term calming effect. This was often followed by feelings of shame and self-disgust, particularly about the wound. Sometimes a build up of tension was described and a variety of triggers such as contact with relatives or unpleasant memories were identified. Others talked about it 'just happening' without really knowing why.

(iv) Self-hate/ punishment/ internalised anger

This strand of explanations was particularly strong among the young people who cut themselves seriously. The cutting arose from a profound sense of worthlessness and self-hatred. Cutting was seen as a justified punishment against the self or as a means of redirecting anger that could not be expressed towards others. The young people who described these experiences did not feel the sense of relief or calm expressed by the former group.

Staff participants described a number of situations where young people appeared to be re-enacting abuse which are consistent with this theme.

(v) Concretisation - Getting bad things from the inside to the outside

This theme was described by all young people. Internal pain and distress is felt to be unbearable and out of control and cutting provides a focus and converts the confusion into a concrete and sure form, providing some form of meaning. Being able to exert some control over the pain was felt to be important as was providing concrete proof of how awful they really feel.

b) Interpersonal explanation

A small number of explanations related to the communicative function of cutting. Central to this was whether staff were made aware of the cutting. All staff said they thought they knew about the majority of incidents because the young people communicated it to them in one way or another. A few young people agreed with this but many were ambivalent.

(I) Communicating level of distress - this is how much I'm hurting

A few young people alluded to the importance of showing staff how they felt inside and this was seen by some staff as important and as an effective way of engaging in a caring interaction.

(ii) Punishment of others

Staff made references to cutting as a way of punishing others, 'see what you made me do'.

(iii) Attention/ status

Several explanations revolved around the theme of playing games to secure staff attention. A related theme was the way in which cutting was used to gain status and acceptance within the adolescent group. These explanations came from some staff and from young people when they spoke about other young people, not about themselves.

c) Types of cutters?

Both young people and staff talked about 'two types of cutters' which bridged the intra and interpersonal explanations. These types were seen as 'serious, sad cutters' and 'attention seeking cutters'. All young people interviewed saw themselves as serious but saw other young people in terms of the two groups.

Several young people highlighted how young people could move between the groups, leading to an inappropriate staff response.

IMPACT OF CUTTING/ EMOTIONS EVOKED IN OTHERS

The impact of cutting on others was very powerful. Similar feelings were evoked in staff and in young people when their peers cut.

(I) Fear and anxiety

This was experienced by all staff when first exposed to cutting and was related to the shock of seeing wounds and anxiety about the risk of death. Over time most staff reported 'getting used to it' and felt a high level of anxiety only around certain individuals who were cutting seriously.

(ii) Sympathy and concern

A small group of staff described powerful nurturing emotions with an urge to protect the young person and this response was observed in the young people.

(iii) Confusion and Impotence

A sense of impotence was universally experienced by staff over repeated exposure to incidents and this seemed to lead to a variety of responses. While some staff expressed anger and frustration, many described feeling cut-off and a general lack of feeling on the subject. Through the process of the interview, many of the staff who were in the 'doesn't bother me camp', acknowledged feeling confused and at times overwhelmed. The impotence linked to feelings of guilt regarding failing to protect the young people from damaging themselves. In some cases it also led to a powerful staff feeling of being persecuted and manipulated. This theme seems intimately linked to the role of carer.

Young people most commonly expressed impotence by keeping out of others' way.

(iv) Anger

Anger was expressed by staff towards the young people and to the family who was seen as having damaged them.

A lot of anger and frustration was also expressed by young people and staff about the contagion of cutting. Young people felt that the copying or catching of cutting trivialised their feelings and universally desired that other young people would not be influenced by their behaviour.

(v) Cut off

This theme generated a lot of discussion across the staff group and was seen as a vital and generally positive coping response necessary for surviving the work.

3) RESPONSES OF OTHERS

This section is divided into (a) staff responses to cutting and (b) young people's experience of responses.

a) Staff responses to cutting

As would be expected, staff responses depended to a large extent on the explanations attributed to the behaviour and personal feelings evoked. Broadly speaking staff responses could be placed on a continuum from a practical care/ repair response through to an intense engagement and working through the issues which at the extremes took the form of a

rescuing response. The impact of the behaviour on the staff group often divided opinion and anger was expressed towards those who took on a different view.

(I) Practical care/repair

Staff expressed a sense of relief around the process of cleaning up. This paralleled the relief described by young people when emotional pain was concretised. Practical care also at times represented the minimum care possible with some staff believing that the behaviour should be ignored but that cleaning needed to be done.

(ii) Engagement/ Rescue

This response seemed an attempt to understand the young person as far as possible and in some cases to 'make up' for past experiences of poor care.

(iii) Staff conflict of opinion

Strong negative feelings were expressed by staff towards colleagues who responded in contrasting ways.

Normalise cutting?

A strong sense of normalising cutting predominated although there were a few dissenting views from those staff who took a more complex position of attempting to hold the potential conflicts in mind.

b) Young people's experiences of responses

The young people gave a variety of differing and often contradictory views which seemed to encapsulate the ambivalence of being cared for as an adolescent and specifically adolescents in a care situation.

(I) Ambivalence about being cared for

A desperate desire to feel cared for was often combined with a desire to be left alone and to take responsibility for themselves.

A few young people were able to verbalise how they understood this conflict of needs, that feeling care was intensely frightening and made them vulnerable to the feelings that they were familiar with.

(ii) Staff don't care and punish you for your feelings

Another strand of experiences was around a profound feeling of not being cared about. This was expressed by the view that it would be better if staff don't know and that staff could never really care properly as they were paid to do their job.

Several young people gave examples of staff behaviour which showed them that not only did staff not care but that they felt angry and punishing towards the young people.

(iii) Do nothing

All young people described impotence in the face of what might be done that would help and many acknowledged that often there was nothing that could be done other than practical care. Many young people saw their cutting as nothing to do with anyone else.

(iv) Accept/normalise cutting?

Most young people felt strongly that staff should accept their cutting as normal and reasonable behaviour but references by many were also made to how non-acceptance was experienced as genuinely caring.

(v) Prevent serious damage

A final theme expressed by almost all young people was around their hope and expectation that they would be protected from doing serious damage to themselves.